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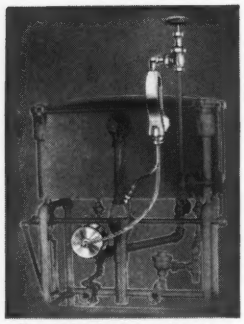
MAY 1946

Hospital CONSTRUCTION Issue

VOLUME 20 · NUMBER 5



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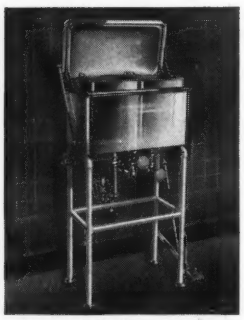
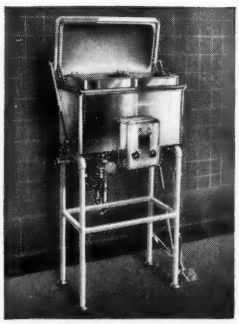


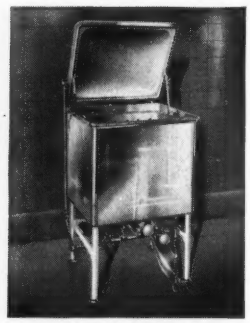
Steam heated instrument sterilizer.

INSTRUMENT STERILIZERS

The Scanlan-Morris instrument sterilizers illustrated are made in four sizes—body and cover of monel or plated copper. The raising and lowering mechanism for simultaneously opening cover, elevating and lowering instrument trays, and closing cover, is operated by foot pedal. An oil check pump makes the lowering of cover and trays noiseless. The two larger size sterilizers are provided with one full size tray and two half size trays. The two smaller sizes have one full size tray only. Tubular steel stands are white enameled with plated brass adjustable floor plates.



Electrically heated instrument sterilizer.

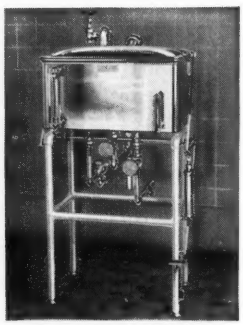


Steam heated utensil sterilizer.

UTENSIL STERILIZERS

The Scanlan-Morris utensil sterilizers illustrated are made in three sizes. Construction and finish is similar to that of the instrument sterilizers except trays which are full deep size, with guide rollers for easy raising and lowering.

When so specified any of these instrument and utensil sterilizers can be mounted on wall brackets in place of floor stands, and can be equipped with the Vent-O-Stat.



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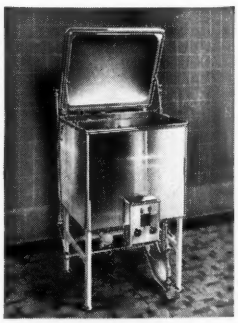

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Sister Peter Francis

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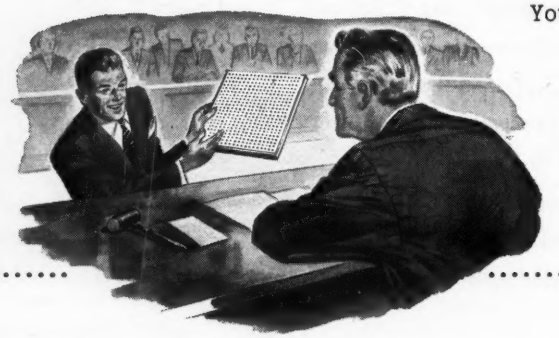
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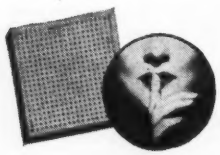

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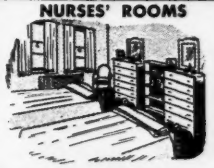

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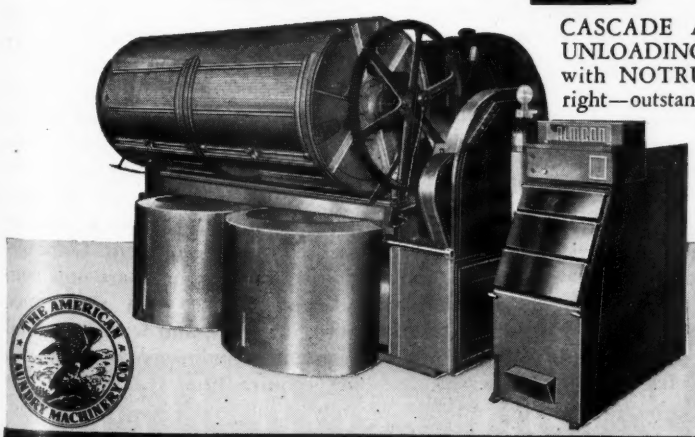

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Just now there is a great deal of staff reorganization planned as former members released from the armed forces are making their decisions as to whether or not they wish to resume their pre-war duties. We are in touch with a great many institutions making changes and shall be glad to learn the type of appointment for which you are available.

•

M. BURNEICE LARSON
Director
The Medical Bureau
PALMOLIVE BUILDING
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Your President Reports

THE MEETINGS which I have attended during the past few weeks have all properly stressed the hospital care needs of returning veterans.

The fact that hospitals are generally crowded at the present time has created a spirit of apprehension over extraordinary demands which the care of the veteran may develop. It has seemed to me that there are two factors which must be borne in mind when we consider this. The first is that while building restrictions may continue for some time, hospital building is now going on and will accelerate as building materials become more readily available.

The second factor which has been emphasized at the meetings I have attended but which needs re-emphasis is that the veteran returned and now returning is the same person who, before he left for service, was cashier in the local bank, the clerk in the corner store, the neighborhood doctor or the factory worker. Most came from the same community to which they are returning. If the hospital could provide for his hospital care before he became a soldier or sailor, there is no reason why the same hospital cannot now provide care to him after he has left military service.

It is true that during military service he was subject to hazards that are unique. But it may be assumed that most of the serious service-connected disabilities will be cared for in the larger veterans' facilities. The problem of the Veterans Administration is one of obtaining medical examinations and care for the more ordinary type of disability and the convalescent.

The voluntary hospitals of America have been given a challenging opportunity for public service by General Bradley and Dr. Hawley, and the Veterans Administration. Their rich heritage of service to the nation in times of peace and war is such that they must not now become fearful because of considerations raised by the too timid. If the veterans who now ask that they may be provided care by their own doctors in their own home towns had been timid when they faced the enemy, our voluntary hospital system would by now have been but an empty shell. Can we do less than meet their needs?

★ ★ ★

The headlines in newspapers and magazines continue to tell the story of the tremendously vital part that Blue Cross is playing in medical and hospital economics. Recent stories in *Time* magazine, the *Farm Journal* and many other publications all are evidence of the strength of this movement. Some hospital superintendents have suggested that, Blue Cross having shown the way, it is time for hospitals to be less interested in the movement. Commercial insurance policies are now considerably better than they once were, it is said, and with improved economic conditions hospitals do not require Blue Cross as desperately as they did a few years ago.

In my opinion, this is a very shortsighted point of view. I remember that when Blue Cross start-

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CHICAGO 13

ed in our city, our voluntary hospitals were being used to less than 50 per cent of capacity. Since then, even though we have continued to build facilities, our occupancy has constantly increased so that for the past few years it has been beyond capacity. While all of this changed picture is not the result of Blue Cross, in my opinion, it is the greatest single factor.

It would be extremely shortsighted of voluntary hospitals and the American Hospital Association to neglect Blue Cross in its hour of triumph, hoping that a competitive spirit, as between Blue Cross and commercial insurance, will result in a more favorable position for hospitals.

It is true that the cash indemnification plan of commercial insurance makes it possible for hospitals to charge extra sums against policy holders, whereas under Blue Cross the subscriber obtains service benefits and may not be charged such sums. It is a vain hope that commercial insurance plans will in the long run be as useful to voluntary hospitals. Too many hospitals are pressing for an indemnity contract. Nothing could be more tragic for hospitals than an increasing trend in this respect.

In the first place, costs of operation of such insurance companies are considerably higher than that of Blue Cross. It must also be remembered that while cash reimbursement contracts may be desirable in good times, they are extremely undesirable in bad times. Before you join the movement to force your local Blue Cross plan into a cash indemnification plan, think back to your hospital occupancy in the days before you had your Blue Cross. Also analyze the receipts you obtained last year from Blue Cross in relation to the receipts you obtain from non-Blue Cross subscribers. After you have these two factors well in hand, I am sure that your judgment will favor more extensive and stronger Blue Cross plans.

★ ★ ★

Dr. Fred Carter's masterly presentation at the New England Hospital Assembly in Boston the latter part of March captioned "Who Pays the Hospital Bill for the Postwar Patient?" which is published elsewhere in this issue, was one of the highlights of the meeting. I strongly urge your careful review of this material, and I think you will find it an interesting comparison, as I have with our own experience. His final comments regarding government compulsory health insurance are so timely and thought-provoking. His statement to the effect that government must demonstrate that it can do a better health job than is being done at the present time by the various health agencies, that he must be so convinced before sponsoring such a compulsory program of health, shows wisdom and sound thinking of one of our leading hospital administrators.

Fred's efforts in this presentation were amply rewarded by the resultant applause.

In comparing our experience with that of St. Luke's Hospital in Cleveland, we find that between 1940 and 1945:

Our per capita per diem cost before depreciation increased	*24.0%*
St. Luke's—Cleveland	*33.5%*
Our per capita per diem salary cost increased	*35.6%*
St. Luke's—Cleveland	*56.4%*
Our patient days for the period increased	*53.0%*
St. Luke's—Cleveland	*0.6%*
In 1940 the ratio of our salaries to total operating expense was	*55.0%*
In 1945 this had increased to	*60.0%*
St. Luke's—Cleveland—1940	*57.5%*
1945	*63.1%*
Our per capita per diem supply cost increased for the period	*9.3%*
St. Luke's—Cleveland	*0.3%*

Dr. Carter states that 15 hospitals in the Cleveland area showed an increase in weighted average per capita per diem cost of 41 per cent in the 5 year period. St. Luke's 33.5 per cent as compared to our experience of 24.0 per cent. Dr. Carter's experience and ours was a little better than that of the Cleveland hospitals above referred to.

Please observe in this comparison that our patient days' care increased 53 per cent from 1940 to 1945. However, we are aware that there are many fixed expenses that would not be greatly affected by this 53 per cent in occupancy.

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Opinions

. . . on expanding the general hospital to include services according to community need

The Question—If you were building a general hospital, for which of the following services would you provide first, and in what order would you expect to add the rest: Chronic care, tuberculosis care, mental care, communicable diseases, physicians offices, public health office quarters, or other?

THE FIRST FOUR SPECIAL SERVICES

IF I WERE BUILDING a new general hospital today, I would, if possible, provide in addition to the facilities now usually supplied, the following:

1. Offices for physicians, if it were possible to provide diagnostic facilities for the use of those so housed.

2. Offices for the public health officer of the city or community.

3. Provision for the temporary care of tuberculosis and for more prolonged care of certain cases when prompt transfer is not possible.

4. Facilities not only for the care of communicable diseases which may develop after admission but, if possible, of additional cases if there is no other local provision.

The care of mental cases in general hospitals is a big problem, for which the smaller communities, at least, are at present not ready. This is not only because of lack of nursing and other personnel, but also lack of physicians. However, every general hospital should have at least two specially designed rooms (one for men and one for women) where proper care and control can be provided for post-operative psychosis and for the emergency mental case. All general hospitals should be ready to accept such patients temporarily even though we dread to admit them.

The care of the chronic patient in a general hospital is receiving more consideration than ever, and rightly so. At the present time I would hesitate to provide such facilities. From an economic standpoint, our costs for the daily care of acute cases in general hospitals are higher than costs in the chronic disease hospital. Even after due allowance for lower nursing and other costs for these patients, the comparison in per capita cost is out of line. We no doubt can learn much from our chronic disease hospitals and in time some general hospitals will be able to care for this type of patient satisfactorily. At present, even though we had a staff of doctors and nurses to care for them, the cost in most hospitals seems prohibitive. — ***Howard E. Bishop,*** *administrator, Robert Packer Hospital, Sayre, Pennsylvania.*

NO. 1: COMMUNICABLE DISEASES

IN THE CONSTRUCTION of a general hospital, we should first give thought to communicable diseases. With improved techniques in the care of communicable diseases in a general hospital, so amply demonstrated by the late Dr. Ben Black at the Alameda County Hospital, we should prepare to admit these patients rather than send them to our county hospitals. Over a period of years at the Alameda County Hospital, nurses caring for obstetrical cases shared the same rooms with nurses on the contagion ward without any instance of cross infection.

General hospitals should also admit for acute illnesses those patients with active tuberculosis. When such a tuberculous patient is admitted, the staff is so informed and, with a well established program, there is practically no risk to hospital personnel.

The planning of physicians' offices especially in rural hospitals is a step in the right direction in building a health center around the institution. The hospital could provide this space at a fee certainly as nominal as the doctor could duplicate in a downtown office building.

It is believed that all forward thinking administrators are contemplating a separate and distinct service for care of the convalescent patient in, preferably, structures built expressly for this purpose.— ***A. A. Aita,*** *superintendent, San Antonio Community Hospital, Upland, California.*

A DIAGNOSTIC CLINIC TOPS THE LIST

IT IS MY OPINION that one of the first facilities which should be provided in a new hospital is a diagnostic clinic. The purpose of this diagnostic clinic would be to provide a thorough physical examination or work-up on every patient desiring it.

Such a clinic could be under the supervision of a pathologist or internist, under the jurisdiction of the hospital. The public health office could be established in the same area as the diagnostic clinic.

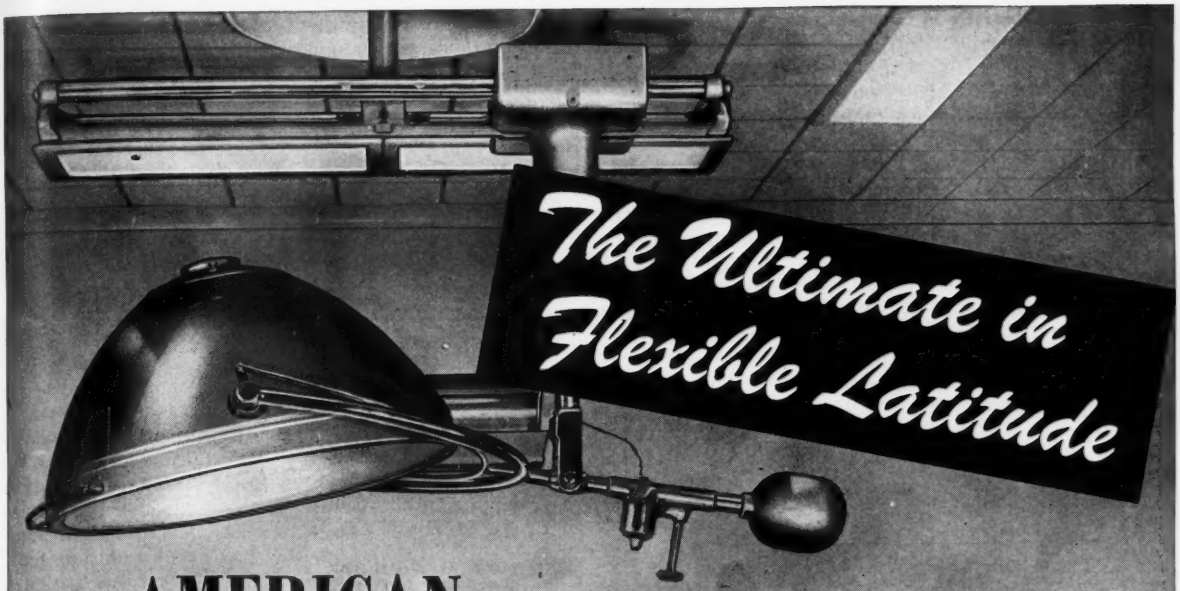
The clinic would not be limited to any financial strata, but a graduated scale of rates would be set, that all members of the community could take advantage of such an arrangement.

It is also my impression that communicable diseases could be taken care of in an isolation pavilion, the pavilion to be used for precaution patients—such as pneumonia, gastro-intestinal and tuberculosis. When an epidemic did arise, these patients could be moved to private rooms and the isolation pavilion used for a specific disease until the epidemic was successfully combatted.—***Howard S. Pfirman,*** *superintendent, Middlsex Hospital, Middletown, Connecticut.*

WHY NOT INCLUDE ALL THESE SERVICES?

MEDICINE IN ITS DEVELOPMENT has so changed our concept of the scope of the general hospital that our question for discussion might well read, "Give one good reason why any one of the proposed facilities should NOT be included in a general hospital where the community had established the need for such a facility."

With this approach I could question only the tuberculosis unit if anything beyond temporary care were contemplated. Modern technics have overcome the hysteria once seen in a general hospital when a tuberculosis case was discovered, but these technics do not replace the fulltime specialized nursing and medical staffs to be



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DESIGNERS AND MANUFACTURERS OF SURGICAL STERILIZERS, TABLES AND LIGHTS

found in tuberculosis hospitals.

With our emergence from the isolation—pest-house and asylum—thinking of earlier days we see clearly how sorry the scheme has been for those patients suffering from mental, contagious and long-term diseases. We see clearly our new role and responsibilities. At least temporary and diagnostic care of the mentally ill must be provided in all general hospitals and full psychiatric units established in the medical centers. The need of the chronic disease patient is for continued medical study as well as nursing care; his welfare will be best served by provision of a special unit within—or adjacent to—the hospital.

There is probably less unanimity of opinion as to the future role of the hospital in the promulgation of programs of preventive medicine. Mass photo-fluorography, tumor clinics, and various types of pay clinics now serving marginal groups are but fore-runners of larger diagnostic programs for all. Physicians advocate yearly physical check-ups, and certainly the findings at induction within the soundest segment of our society leaves no question of the course to be pursued if better health for all is to be realized.

The hospital with its x-ray and clinical laboratories seems the logical place to develop these mass diagnostic facilities. In addition, the intern and resident staffs must have increased dispensary and out-patient experiences to round out their training. My plans, therefore, for this perfect general hospital would anticipate a tremendous increase in the areas devoted to out-patient clinics.—***Van C. Adams, superintendent, Jewish Hospital, Cincinnati, Ohio.***

ISOLATION UNITS ARE NEEDED MOST

IN THE GENERAL HOSPITALS of this community it seems that the lack of facilities for communicable diseases is the most outstanding. We need more isolation units for care of the sick and for teaching programs. At the present time, only the most severe of the communicable disease cases are cared for, and then there is a question as to isolation technique insofar as the other patients, visitors and personnel are concerned.

Care of the mental patient seems next in line. In our particular community and even statewide, this seems ignored. The classifications under mental care are increasing so rapidly that it is hard to determine to what extent general hospitals are answering this need. We do not, however, provide anything like enough facilities.

Next, we should increase our facilities for chronic care. Most hospitals are too crowded even for acute cases, but that does not relieve us of an obligation. Chronic disease patients are being given only acute care, after which they must make their own arrangements. We know this care is insufficient for many are readmitted in an acute condition.

The providing of facilities for physicians' offices and public health quarters would seem to depend on the local demand. The staff physicians' wishes influence our administration and if they wish office space, certainly consideration should be given. It should be kept in mind, however, that the laws of the states vary in regard to taxation in enterprises such as these. Our program and that of the public health divisions are becoming more integrated every day.

Regarding facilities for other services, it seems that convalescent care is more important than some of the above services. In our own community it should follow the provision of facilities for mental care.—***B. Tol Terrell, administrator, Harris Memorial Methodist Hospital, Fort Worth, Texas.***

Atopic Eczema

IN MANY INSTANCES YIELDS

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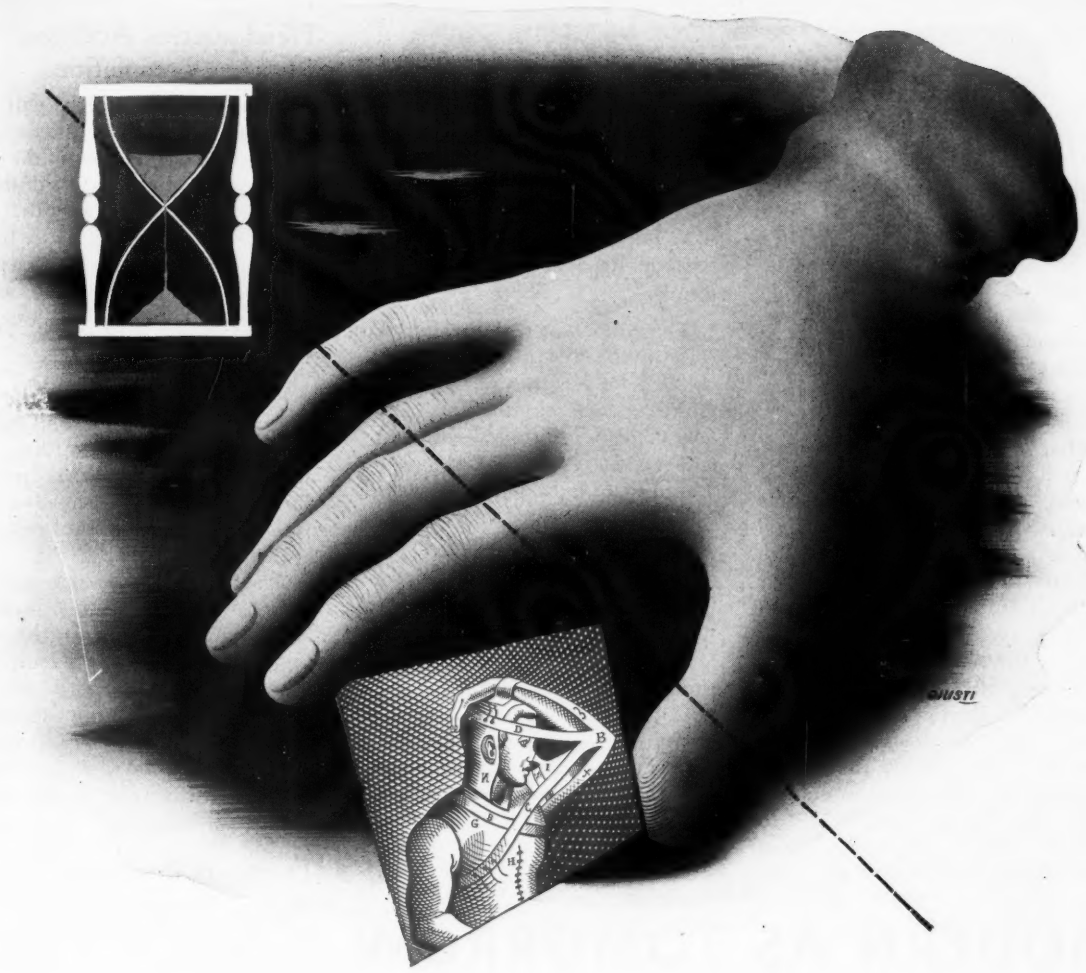

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Service From Headquarters

'Reference Guide' For Hospital Problems

The current literature of hospital administration often seems to suffer from chronic repetition. Again and again the old familiar problems are brought forth and given ink-and-paper treatment with equally familiar solutions.

What might be done about repetition has been the subject of discussion at headquarters for some time. An arbitrary barring of all such material could hardly be justified. Sometimes one of the familiar old solutions is given a new twist, and this makes good reading matter even for veteran administrators who carry the basic information around in their heads. Besides, there is a fairly constant influx of new executives to whom the routine problems of operating a hospital are strictly current problems.

As a result of discussion and a considerable amount of work in the Bacon Library, the headquarters staff believes it has found a way to serve both the well-read administrator and his recently inducted colleague.

The June issue of HOSPITALS will contain the first of a series under the general heading of "Reference Guide." Each installment in the series will be concerned with a specific routine problem of hospital administration. Each will include a listing of reference material available in the Bacon Library, with a thumbnail review of every item listed. The series will run indefinitely.

It is not intended that publication of the "Reference Guide" cut off all the discussion in HOSPITALS of the basic problems. Rather, it is hoped that such a continuing supplement of standard literature will make it possible for HOSPITALS to devote more space to new problems and the newer angles of old ones.

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Headquarters Addition Nearing Completion

Improvements which will add 2,000 square feet of usable office space to the second floor of the headquarters building are scheduled for completion early this month.

This step was authorized by the board of trustees last February and involves construction of a second floor in the Bacon Library area with a ceiling height of 12 feet in the library proper and 11 feet on the new floor, which will be at the same level as the existing second floor in the front wing of the building. This will permit better lighting and heating of the library as well as the installation of an acoustical ceiling in that room.

The space being made available will be used for the offices of the editorial department of HOSPITALS and the staffs of the Councils on Associational Relations, Administrative Practice and Public Relations.

The construction is steel and reinforced concrete with paneling in the new area similar to that now in the Bacon Library.

Dietary Consultant Begins New Duties

S. Margaret Gillam has arrived at headquarters and begun her work as dietary consultant of the Association. The former director of the nutrition department at the Society of the New York Hospital, New York City, will be in charge of Association activities aimed at improving dietary administration in hospitals, and will prepare material on the subject for publication in HOSPITALS. In an advisory capacity, Miss Gillam will assist members communicating with headquarters.

Jesuit from India Is Recent Visitor

The Rev. John Barrett, S.J., an American missionary on leave of absence from religious duties in Patna, India, visited headquarters recently, conferring with the Association's research director on ideas for hospital improvement in India.

Primarily interested in suggestions for the erection of a proposed 500-1,000 bed hospital in Patna, Father Barrett discussed tentative plans which schedule construction

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for the immediate future. The new institution will be under the direction of a group of Catholic Medical Missionary Sisters whose novitiate is in Fox Chase, Philadelphia, and who have trained at Fox Chase General Hospital. According to Father Barrett, the hospital staff will include Hindu doctors among whom will be at least one Hindu woman doctor.

In this country since last June, Father Barrett will remain until the fall.

Palestine Doctor Is Also Visitor

Furthering his study of American hospitals in connection with the contemplated expansion of 160-bed Beilinson Hospital in Petah-Tiqva, Palestine, H. Heller, M.D., medical superintendent of Beilinson, recently met with members of the headquarters staff.

According to Dr. Heller, the institution's expansion program calls for the addition of 400 beds. The hospital—one of five belonging to the sick fund of the Jewish Federation of Labor of Palestine—will include 12 units for general medicine and surgery and the various specialties.

Dr. Heller entered this country last December. His plans called for return to Palestine late last month.

State Association By-Laws Reviewed

In compliance with the request of a state hospital association, the secretary of the Council on Association Relations recently reviewed the state association's by-laws, submitting a critical analysis of specific articles together with constructive suggestions for improvement. Some of the suggestions, applicable to all state hospital organizations, follow:

With respect to dues and initiation fees it is sufficient to state that the board of trustees shall have the power to fix dues for the state association in such amounts and payable at such times as they shall from time to time determine.

There should be provision for membership of Blue Cross Plans. (This is required for affiliation.)

Except in a very large association it is not practicable to have a committee on coordination. The chance are there will be too much duplication of effort between the board of trustees and coordinating committee. The operation and administration of the association would be eased by having the board of trustees function fully, with perhaps the chairmen of committees on particular projects invited to meet with the board on occasion. In this way it is possible for the board to keep more direct contact with activities.

In his study of the by-laws of hospital organizations, the council secretary reports evidence of a general tendency on the part of hospital groups to crowd excessive wordage into the laws. "Like most others, hospital by-laws," he maintains, "are entirely too wordy . . . I am of the opinion that the hospital organization should be a living, changing thing . . . that it should be interpreted in keeping with the times . . . that the board of trustees should be given latitude to indicate the course to be pursued by its action."

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HOSPITALS
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Who Will Pay Hospital Bills for POSTWAR PATIENTS?

FRED G. CARTER, M.D.
SUPERINTENDENT, ST. LUKE'S HOSPITAL
CLEVELAND

THE FIGHTING PART of World War II is over and we are in the process of substituting a new collection of problems for those of the war years. In this process we hear and read much about reconversion, but there is no opportunity to retrace our steps and resume our activities where we left off on December 7, 1941.

We can't retreat to "normal"; we can only advance to new "normals." The past is dead and gone forever; it belongs to the historians. We can only adjust to things as they are and as they may be. It is true that we can recall the past and select from it such lessons as may be valuable to the world and to the mode of life which we are now formulating, but otherwise it has little to offer.

Hospitals, in their process of adjustment, are concerned over many things, and one of these is the answer to the question: "Who pays the hospital bill for the postwar patient?" To find a reply requires a lot of rummaging around in hospital economics, hospital history, trends—past and present—and governmental and public attitudes.

Answers to such questions as the following must be sought: What has been happening to hospital costs in the last five or six years? How large were prewar hospital bills? What do present hospital bills look like? What are they likely to be in the future? Who has paid hospital bills in the past? Who pays them now? Who is going to pay them in the future?

From an address given by Dr. Carter at the New England Hospital Assembly, Boston, March 11-13, 1946.

REPRINTS — Many persons who heard Dr. Carter's paper at the New England Assembly meeting asked that reprints be made available for distribution to their board members. All orders of 25 or more received by May 20 can be filled promptly at nominal cost. Please address HOSPITALS, 18 East Division Street, Chicago 10.

HOSPITAL COSTS

In attempting to find an answer to the first question, I have turned to the experiences of my own and 15 other hospitals in the Cleveland area which have kept uniform accounts for many years. In my own institution, between 1940 and 1945, the per capita per diem cost, before depreciation, increased 33.5 per cent. Our per capita per diem salary cost increased 56.4 per cent. It is interesting to note in this connection that the number of employees dropped 14 per cent while the patient load remained almost constant with an increase of only 0.6 per cent. A much larger salary load was distributed among fewer people.

Translated into terms of individual salary increase, the per capita per diem salary increase becomes an individual salary increase of 65.3 per cent. Per capita per diem salary cost in 1945 was $6.94 compared with $4.44 in 1940 when the total per capita per diem cost was only $7.72. Thus, salary costs alone in 1945 were almost equal to total

costs back in 1940. The ratio of salaries to total cost was 57.5 per cent in 1940, but by 1945 this ratio had increased to 63.1 per cent. Most hospital people will remember the days when we used to think that 50 per cent or less of the total budget was adequate to cover salaries. Our per capita per diem supply cost increased only 0.3 per cent between 1940 and 1945.

Fifteen hospitals in the Cleveland area show an increase in weighted average per capita per diem costs of 41 per cent in the five-year period, which would indicate that the figures for my own institution may be more conservative than typical. If hospital billings reflect hospital costs, as they should, the average hospital bill of today in our area is about 40 per cent higher than it was in 1940. If the trend of the last five years continues for the next five years we may expect that the prewar bill of $6 to $7 a day will have advanced to $12 to $13 a day in our community by 1950.

Some hospitals are already at this level or higher. Perhaps we shouldn't worry about these possibilities and I don't think we would, if we could be assured that we are not rapidly approaching the point of diminishing returns both from the health and financial standpoints.

FACTORS PROMOTING FURTHER COST INCREASES

Some meager signs of a reversal of the trend in hospital costs were evident in the latter part of 1945—at least there seemed to be a slight slowing down of the advance. Certainly everyone hopes that there will be a definite tendency toward a leveling off process in hospital costs in the years immediately ahead. We can't afford, however, to ignore certain factors which are at work in the direction of promoting continued rises in hospital costs. Among these are the following:

1. Threat of the extension of the 40 hour week to the hospital field with substantially no reduction in individual pay. A standard work week of 40 hours is quite strongly entrenched in the public mind.

2. Demands for increased pay to match compensation paid in industry, business and government.

3. Employment of additional people to fill gaps in hospital staffs created by wartime labor shortages.

4. Constantly rising commodity costs after removal of price controls until laws of supply and demand again assert themselves.

5. Demands for increased amounts of service and equipment to keep abreast of advances in the field of medicine.

6. Increased maintenance and replacement costs resulting from forced neglect of such matters during the war period, unless depreciation reserves have been funded to meet this situation.

7. Trend toward all inclusive contract rates which makes the control of volume of adjunct services and supplies difficult.

8. Greater educational effort on the part of hospitals with special reference to the needs of the returned veteran.

9. Declining interest in volunteer work in hospitals.

10. Inflationary trends in general.

FACTORS TENDING TO REDUCE COSTS

Offsetting the factors tending to promote continued rises in hospital costs are those which tend to reduce costs. These seem rather anemic in comparison when balanced against the former, but they are important and some of them are listed herewith:

1. Better selection of personnel when and if choices are offered.

2. Better training programs for personnel designed to make individual employees more efficient, thus reducing the number needed.

3. More thorough job analyses and better job classifications.

4. Inauguration of short training programs for young men and women for the lesser tasks of nursing.

5. All unnecessary procedures should be eliminated in the hospital.

6. The idea that all patients are totally helpless should be eliminated.

7. Give further consideration to the abuses and dangers of bed rest in the treatment of patients by the medical profession.

8. Shortening of the length of stay of patients in hospitals which probably will increase unit cost of care but decrease individual hospital bills.

9. Better adjustment of hospital care to actual needs of patients.

10. Better planning of hospitals.

Thus far I have discussed hospital costs, past, present and future, and have indicated that bills to patients probably directly reflect these costs. I have also pointed out some of the factors that are influencing the cost and price trends in hospitals favorably or unfavorably. The next set of questions has to do with those who pay the hospital bills.

PRE-DEPRESSION PAYMENT METHODS

In the days before the great depression of the early 30s, from which the nation emerged only after the stimulation of a wartime economy, hospital bills the country over probably averaged less than $6 per day and were paid, for the most part, by the individual who benefited from the service from his own private resources. There was some contract work on workmen's compensation cases. Insurance companies took care of bills in a small number of cases and my experience with insurance company representatives in those days made me believe that I was dealing with a pretty tight-fisted group.

Governments made token payments for the care of indigents in those cases where governmental hospitals did not exist for the benefit of the indigents. Private philanthropy of one kind or another, including community chests in some instances, took care of the deficits. Hospitals followed what might be described as a system of tin cup economics, and were a favored beneficiary of charitable impulses.

GROUP HOSPITALIZATION

In the early 30s the group hospitalization movement began to attract widespread attention. Designed at first as a means of taking up the slack in hospital finances caused by the inability of low income groups to meet hospital bills, this method of underwriting the risks involved—by groups of individuals in relation to the need for hospital care—has been applied to upwards of 20,000,000 people in the United States without limitation because of individual financial circumstances.

In the community with which I am identified nearly 60 per cent of the population now carries this coverage. I thing it can be said that a majority of our patients have their hospital bills paid for them by the Blue Cross plan. This method of financing hospital care continues to grow spectacularly and the proportion of patients who pay their hospital bills out of their own resources declines almost as spectacularly.

The growth of hospital insurance plans has brought with it certain problems. One of the most important of these is the question of payments to hospitals and there has been much discussion of this question in the last few years. Flat rates of various kinds, established rates

and cost related rates have been used as methods of reimbursement to hospitals. This much seems obvious: regardless of the method used, hospitals cannot afford to take care of ever increasing proportions of their patients for any figure which represents anything less than complete costs.

Blue Cross plans also have their rate problems. In their infancy it was calculated or guessed that hospital utilization could be figured at the rate of one day of hospital care per subscriber year. This still seems to be a fairly safe assumption in the light of the experience which the plans have accumulated during their existence. The most recent figures which have come to my attention indicate a utilization of 0.8 to 0.9 of a day per subscriber year. An annual premium rate of $7.20 for ward subscribers and $9 for semi-private subscribers seemed ample, and proved to be so, to cover hospital costs, plan overhead and reserve requirements when hospital costs were averaging not more than $6 to $6.50 per day in the communities where plans were organized. Many plans were even able to expand benefits under these conditions.

If hospital costs have increased approximately 40 per cent since the prewar era—as has been shown to be the case in at least one large community—then it stands to reason that if the original premium rates were sound, present premium rates should exceed the original by something approaching 40 per cent or what ever amount represents the increase in hospital costs, plan overhead and other expenses since the original rates were established. With hospital costs increasing rapidly it does not seem likely that Blue Cross plans can continue to operate and meet their complete obligations without commensurate and justifiable increases in their premium rates. On the other hand, if Blue Cross plans do not meet their complete obligations, hospitals will have to look elsewhere for support or close their doors.

PAYMENTS BY GOVERNMENTS

In recent years governments under the leadership of federal authorities have shown a disposition to meet the fair costs of hospital services. This idea has not yet trickled down to state and local units of government to any great extent, but the pattern is being drawn and eventually may be made applicable to all branches of government. The Children's Bureau of the Department of Labor has been setting the pace by allowing cost plus 10 percent to cover depreciation, interest on investment and use of capital. This is the well known Emergency Maternity and Infant Care Program, familiar to all as EMIC. This is now operating in its fourth year.

In the beginning EMIC was intended as an emergency measure only, but indications are that it may be continued for a time at least.

The Office of Vocational Rehabilitation has adopted the EMIC formula and now the Veterans Administration is negotiating for the care of veterans on the same basis. It is not unreasonable to expect that sooner or later all branches of government that have been purchasing hospital service may be prevailed upon to adopt similar methods of reimbursing hospitals for the care of patients. At any rate the precedent has been set by departments of the federal government which are comparatively large purchasers of hospital service.

CONTRACT SERVICE

At this point it is interesting to refer again to the experience of the 15 hospitals of the Cleveland area. I realize that their number is too small to constitute a fair statistical sample but the growth of contract service among them represents a trend that is worth noting. In 1945 only 33.9 per cent of the total patient days in these institutions were classified as the "regular pay" type.

Of the remaining 66.1 per cent, 3.9 per cent were part-pay and free and 62.2 per cent represented patients whose bills were paid on some kind of contract basis by insurance plans of one kind or another, by units of government or by the Community Fund. It should be obvious that hospitals, whether they like it or not, are finding increasingly larger proportions of their bills being handled on the basis of group contracts. The experience of the Cleveland hospitals is probably in line with the trends in such relationships all over the country.

From the foregoing comments on methods of paying hospital bills it appears that hospitals in the future —if they follow traditional, evolutionary trends rather than totalitarian precepts—must look to three main sources for payment for the services which they render: The patients, themselves, in decreasing numbers, governments — national, state and local, and voluntary insurance.

The ranks of the "regular pay patients" are thinning rapidly. In some communities these payments no longer represent the backbone of hospital income. The time will soon pass when we can bolster sagging income by raising rates to this segment of our patients. Furthermore it isn't quite fair to ask this shrinking group to shoulder the burden of meeting hospital deficits resulting from entrance into contracts to care for large groups of patients at figures representing less than the complete cost of furnishing such care. We have every right to be more and more concerned about the fixed character of our earnings under contracts in a period of rapidly rising costs and we have an obligation to our institutions to see to it that fixed earnings are high enough to guarantee solvency.

With the absorption of private philanthropy by governments through high taxes it seems only fair that governments should assume the burdens which private philanthropy has carried for generations in the hospital field. This means that governments must accept the responsibility for the care of the indigent and the medically indigent at rates representing nothing less than complete costs. It does not mean that governments must accept a responsibility of this nature for everybody.

Voluntary insurance plans, including those of insurance companies as well as those of Blue Cross corporations, probably are paying the hospital bills of 30,000,000 to 40,000,000 of the people currently and this group will continue to grow at the expense of the so-called "regular pay patient" group. If these plans are to survive and expand, as we hope they will, they must ex-

pect to pay hospitals the complete costs for the care of their clients.

The real issue at stake in all of the nationwide discussions of health care has to do with the plight of the indigent and the near indigent. All of us can agree that something must be done about this situation. If it is admitted that the medical needs of the vast majority of our people are well taken care of and that our concern should be for the low-income and no-income groups, then legislation should focus on these groups and not on the entire population.

Certainly, if a man fractures a bone in his forearm you don't treat every bone in his body for fracture. Similarly, if a small segment of the population is in difficulty from the standpoint of health care, you don't have to subject the whole population to corrective measures to get the small segment of population taken care of. Federal grants in aid, administered through the states in some such fashion as the Emergency Maternity and Infant Care program is now administered, would take care of the indigent and the near indigent for less than 5 per cent of the cost to government of such a plan as the Wagner-Murray-Dingell bill contemplates. We need a certain amount of help with this indigent problem but not at the price some would ask us to pay.

THE ALTERNATIVE

If traditional methods do not meet the issue, or are deprived by governmental fiat of the opportunity to meet the issue, an alternative is already in the making in the Congress of the United States. Some of the Congressmen seem to have totalitarian concerns for our health as well as for many other things.

The government has taken over control of my pocketbook, evidently on the assumption that I may know how to earn money but I don't know how to spend it. I am denied the right to buy and sell goods and services without governmental supervision and restriction. My constitutional right to the pursuit of happiness has been abridged so that minority groups may have their freedom preserved at the expense of the freedom and well-being of others.

A favored few are encouraged in the perpetration of social atrocities for which the less favored would be jailed or executed as convicted criminals.

Extra-legal bodies are permitted to make and enforce their own laws without recourse on the part of those who offend against these laws and the manner of their enforcement. Monopoly in restraint of trade is a crime for one group and eminently legal for another. A national debt of $275,000,000,000 is of no concern to us "because we owe it to ourselves." We create wealth by destroying it.

All of this is part of the record of recent governmental attitudes and philosophies and now there are those who would ask me to give over into the keeping of government the most precious thing in life that I possess—my health. When governments have demonstrated their ability to handle the responsibilities with which they are now charged, I will be willing to listen to their proposal for collectivistic medicine, but I want to make it clear that I will be impressed only by their record, not by their promises. I shall always keep in mind, too, that courts find it difficult and sometimes inconvenient to say what legislators mean.

BED TIME STORY

Once upon a time a dog, carrying a large piece of meat in his mouth, was crossing a bridge over a deep stream. He paused at the middle of the bridge and looked down into the stream. There he saw a larger dog with a larger piece of meat in his mouth. He leaned further and further out over the edge of the bridge, and the further he leaned, the closer the dog in the stream approached. Finally he could contain his envy no longer. He dropped his piece of meat into the stream below and plunged in, only to find that his own piece of meat as well as the other dog and his piece of meat had disappeared. Being an intelligent dog he is no longer deceived by reflected promises. He had exchanged what he possessed for a glowing promise that didn't materialize. In the end he lost everything.

WHILE the cost of living soared 131 per cent between 1900 and 1944, average hospital cost per admission increased only 70 per cent, the annual report of the Bridgeport, Connecticut, Hospital demonstrates. The cost of living index has risen from 55 to 127. Average cost per patient day at this hospital now is $6.57; in 1900 it was $1.19. Total cost per patient, which was $38.08 in 1900, has increased to $64.90 in 1944.

Although cost per patient day has markedly increased, the reduction in average length of stay per patient has tended to curb patient cost increases. If the dollar had the same purchasing value in 1944 as it did in 1900 the total cost per patient admission to the Bridgeport hospital would have been $28.01 compared with the cost of $38.08 at that time. A table of costs at the hospital follows:

Year	*Average Daily Census*	*Days Average Stay in Hospital*	*Average Cost per Patient Day*	*Average Hospital Cost per Patient*	*Cost of Living Index (1935/39=100)*
1900	75	32.0	$1.19	$38.08	55.0
1910	111	21.6	1.58	34.12	66.0
1920	192	12.9	3.71	47.85	138.3
1930	279	11.1	4.58	50.83	115.3
1940	348	11.2	4.91	54.88	100.7
1941	361	10.6	5.35	57.00	110.5
1942	370	10.1	5.86	59.34	120.4
1943	359	9.9	5.99	59.31	124.4
1944	337	9.9	6.57	64.90	127.0

The 1900 and 1910 index numbers are from "Real Wages in the United States 1890-26" by Paul Douglas. Figures furnished and converted to 1935-39 bases through the courtesy of the United States Department of Labor, Bureau of Labor Statistics. Index for period 1920 to date from Labor Bureau Consumers "Price Index" measuring the changes in retail prices of selected goods, rents and services bought by families of wage earners and lower salaried workers in larger cities.

About Construction, the Big Question Is: WHEN CAN BUILDING BEGIN?

ROY HUDENBURG
SECRETARY, COUNCIL ON HOSPITAL PLANNING AND PLANT OPERATION

A NEW QUESTION MARK has appeared on the agenda of the hospital building committee. The new question added to all the others confronting them—"When are we going to be able to start actual building?"—arose with the issuance of Veterans Housing Program Order No. 1, which limits construction activity to housing work.

The order provides that applications can be made to local construction field offices for authorization to proceed with work other than housing and indications are that hospitals able to establish the urgency of local need will be given prompt consideration.

Architects advise, however, that hospitals planning to start construction now should make certain of their sources of material supply, since priorities for types of building other than housing will not be readily available.

From any ordinary, commonsense viewpoint, it seems inconceivable that the government can follow any course that will indeterminately continue the bed scarcity that has plagued hospitals since the imposition of wartime restrictions.

Seven of every ten hospitals expecting to build have not yet completed their planning and are confronted with more immediate and pressing problems. Initially, the community must find out whether it can support a hospital. Other communities wanting a hospital are troubled because adjacent towns in a common area that can support only one hospital are also planning to establish hospitals for themselves.

Many established hospitals, as well as hospital-minded communities, are deeply concerned with questions of how many beds they need and how many they can afford, what additional facilities will provide minimum adequacy and whether, once erected, these provisions can be properly maintained.

Problems of the planning stage have an equal potency to tax the administrator and the building committee: How are we to select an architect? Should we engage a hospital consultant? How are we to select him? What will the building cost? What new developments in hospital construction should we ask our architect to investigate or incorporate in our building?

"IF PLANS for construction of a hospital are now completed and if the hospital can demonstrate an actual community need for its additional offered facilities, application for construction should be made immediately and will probably be granted. This is not an opinion; it is the stated policy of the Civilian Production Administration and Housing Expediter Wilson Wyatt.

"In some localities materials will not be available immediately, but it is my opinion that the construction of needed hospital facilities will be able to get under way without too much difficulty during the next six months — THOMAS H. CREIGHTON, Editor, *Progressive Architecture* (Architect - Member A. H. A.).

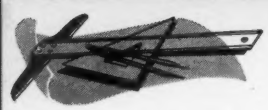
Equally pressing questions are such as these: What can we do to help the architect in expediting our plans? How soon can we hope to break ground after the architect starts his work? How can we finance the building?

Major worries are confronting even the hospital organization that has completed plans and seen its fund raising campaign brought to a satisfactory close. It finds that reconversion ailments have curtailed payments anticipated on the basis of 1945 pledges. It is faced with the cold truth that its building fund will buy less hospital today than when the size of the hospital was determined two years ago or last year.

Building costs have been steadily rising. Current prospects of these costs being stabilized are so uncertain that contractors hesitate to submit bids or more work than is absolutely necessary to keep their key crews busy. Contracts for work of the most urgent character often must be awarded on a cost-plus-fee basis.

Much material in this issue of HOSPITALS concerns itself with various facets of these questions. Other aids for the administrator or building committee have been or are being developed by the Association and its Council on Hospital Planning and Plant Operation.

To assist committee establishing new hospitals and others contemplating expansion in making many of the decisions that face them, the Association devoted Book I of its 1945 Hospital Review—The Individual Hospital—to their problems. Sections titles are: Measuring your Community for a Hospital; the Governing Board of the Hospital; Organization of the Medical Staff; and Administrative Aspects of Hospital Planning. Their author is



W. P. Morrill, M.D., director of research for the Association.

Originally distributed to the Association's institutional membership, the volume is now available for purchase or loan from the Bacon Library. The first three of the four above-named sections may also be purchased in pocket-sized reprints.

The Bacon Library from its file of information taken from periodical journals continually provides answers to specific planning problems. The director of research, the secretary of the Council on Hospital Planning and Plant Operation and other members of the headquarters staff are available to answer similar inquiries made both in person and by correspondence.

Two photostated reprints of data are available through the Bacon Library. The first—bearing the same title as the first section of The Individual Hospital but containing different material—is called "Measuring Your Community for a Hospital" and covers problems up to the start of architectural planning. The second, "Planning the Community Hospital," deals specifically with architectural aspects.

For hospital committees concerned with regional needs a new source of assistance has developed —the agency conducting the state hospital survey. Already established in 39 states, the surveys are in various stages of development and progress. They are being instituted under the guidance of the Commission on Hospital Care, which was sponsored by the Association and established for a two-year span in October, 1944.

Believing that architects familiar with hospital requirements are best suited to produce design that will result in efficient hospital operation, the Association has undertaken the creation of a roster of hospital architects. It recommends that qualified hospital architects be employed for all hospital projects and that, if such a course cannot be followed, the services of an architect not so qualified should be supplemented by the engagement of a qualified hospital architect in a consulting capacity.

The initial roster of architects approved by the Association is published in this issue. While the geographical distribution of those on the list still leaves some areas without representation, it is the aim of the Association to enlarge the roster as rapidly as possible.

As a further aid to the administrator or a building committee that wishes to select an architect, HOSPITALS this month also publishes recommendations on the subject written by James R. Edmunds Jr., and Henry H. Saylor, respectively president of the American Institute of Architects and editor of its journal.

Inasmuch as there has been no practical basis for the establishment of an approval program for hospital consultants, the Association cannot offer similar advised guidance in that sphere. Since there is, however, substantial demand for information about hospital consultants, headquarters has collected data sheets describing the qualifications and backgrounds of individuals and groups acting in that capacity. In this collection, available on request, are included data sheets for any consultants who wish to avail themselves of the opportunity for circulating their qualifications.

Other available aids to planning include the Bacon Library collection of hospital plans. These are not circulated, but may be consulted at will in the library. The Bacon Library is also custodian for the drawings submitted in the recent *Modern Hospital* architectural competition. These will be available for exhibit at hospital meetings.

AND WHAT WILL IT COST?

QUESTIONS of immediate importance to the hospital about to enter into a definite construction program have been submitted to the architect members of the Association in order to obtain their advice. The summary of their answers, particularly as to construction costs and the immediate prospects for beginning work, may be disturbing to those hospitals which have a desperate need for expansion.

A slight majority of the 17 architects who cooperated in the survey believes that the immediate beginning of construction is not advisable, due to unsettled costs and material scarcities. Their estimate of probable costs is, in general, higher than most administrators have probably anticipated.

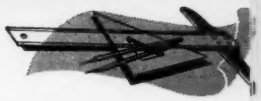
In answer to the question asking the tentative date when construction might be started if plans were now complete, one architect said, "Even though permission were received from Civilian Production Administration I would advise postponing work until we can be sure of necessary materials now in the bottleneck category. These materials include pipe, brick and lumber. Today reliable bona fide competitive bids are unprocurable; therefore, I would advise delaying just as long as possible, as an economic advantage."

An Eastern architect said, "Conditional on the labor and material market, in our opinion, the building industry will not be sufficiently stabilized for satisfactory construction progress before early Spring of 1947."

Another comment was, "Recommend deferring construction for at least a year." Another architect stated that at present prices, costs are enormous and a policy of watchful waiting for a more favorable market is advised.

This outlook was not universal; seven of the replies indicated that while there might be some delay, work might be started as soon as possible. Most of the architects felt that, if economic conditions were satisfactory and plans were completed, work could be started approximately 30 days to six weeks after the decision was made to secure bids.

Those architects referring to the federal restrictions on building other than housing, in general share the belief that the federal attitude toward hospital work will be favorable. A New York man reported that the Civilian Production Administration office in New York made the announcement that



there will be no delay in approving applications from hospitals. Such field offices have the right to approve projects up to $1,000,000 on the basis of comparative essentiality.

On the subject of costs, the only factor on which there seems to be agreement is the unpredictability of prices and their certain upward trend. Estimates on the probable cost per cubic foot ranged from $1 to $1.35 before provisions for equipment not built into the structure. This equipment is normally considered to add approximately 15 per cent to the overall costs of the hospital.

The mean of the estimates for cubic foot costs is approximately $1.15, or approximately $1.32 when the cost of equipment is added. This rate would establish a cost per bed in the neighborhood of $8,000.

Few estimates on cost per bed were below $7,000; a substantial number ranged as high as $10,000 to $11,000 per bed. The mean point of the estimates was approximately $8,800 per bed. These figures do not include provisions for the housing of nurses.

The uncertainty of the cost outlook is demonstrated by the answer of one architect who said, "Unit costs are not a reliable guide under present conditions. We can only estimate at present by taking a quantity survey of materials."

The answers generally agreed that hospitals wishing to provide new facilities should begin their architectural planning immediately. The time necessary for this phase of the work, from the day the architect is engaged until working drawings are ready for the taking of bids, varies in the answers, from six months to one year. This variance is attributed to the size of the project, the amount of work in the architect's office and the degree of cooperation provided by the building committee or the administrator.

The amount of work the architect can undertake is limited now by the scarcity of trained architectural draftsmen and designers. This factor is one that argues further for the beginning of architectural planning at an early date.

Because the present personnel of some hospital organizations may have little or no experience with construction and are interested in what they can do to expedite the architects' work, the survey asked opinions on this subject. While the various opinions approached the problem in various ways, the general consensus is that the administrator can be most helpful by developing as nearly as possible a complete schedule of facilities to be incorporated in the new building.

THESE QUESTIONS WERE ASKED

1. What is your present advice to a hospital badly in need of major construction as to the tentative date when construction might be started, if plans are now complete?

2. If a hospital is badly in need of major construction how soon should architectural planning get under way, and what is the minimum time necessary between the engagement of the architect and breaking of ground?

3. What is your idea of the likely current cost per bed fully equipped? of likely current cost per cubic foot including all fixtures but not loose equipment?

4. In what manner can the administrative executives of the hospital be most helpful to the architect in the planning of a good building?

5. What do you consider the most important consideration in the selection of a contractor?

That this need for cooperation extends to the various department heads is illustrated in the following expression,

"The administrative executives of the hospital can be most helpful to the architect by giving him a full measure of their time, and arranging that the various departments do likewise, furnishing the architect with all the information as to their needs.

"The administrative executives should carefully scan the departmental requests for space so as to eliminate extravagant demands. Unless the hospital administrative executive assumes a hard-boiled attitude toward excessive space requests from the various departments, it is very difficult for the architect to keep overall planning within budget limits."

Where the hospital executives have not been able to arrive at a specific conclusion on the details of needed facilities, it is also suggested that the architect be given access to hospital records and information bearing on local attitudes.

The following suggestion carries out this thought: "If the administrative executives of the hospital will give the architect access to their records for several years, he can, before starting sketches, make a series of studies to show bed occupancy, demand for private, semi-private and ward accommodations, and similar data to arrive at an estimate of future needs. For this study the architect will also require local population and birth figures, a brief analysis of the character of the population, and a description of hospital facilites in the surrounding areas."

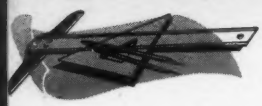
The place of the hospital administrator in the mechanics of planning is described by a middle-western architect in the following paragraph:

"The administrator alone represents, in his person, the owners and users of the hospital; he alone has complete knowledge of all the operations peculiar to his hospital.

"His advice and views should be available from the inception of the project; he should be empowered to carry out the wishes of the board of trustees and his advice to them about such matters should be respected. He is the liaison officer between the board, medical staff, and the architect.

"If the administrator is to be successful in this role, he must keep his own prejudices in the background and endeavor to temper the prejudices of others, to the end that he may act as an impartial clearing house of information and requirements. All efforts should be coordinated to secure a building convenient, well arranged, and with a maximum of accommodations but a minimum of maintenance cost."

Similar dependence upon the administrator, but an arrangement



that to some extent ameliorates the serious responsibilities of the individual, is suggested in the following statement:

"The architect can be most ably assisted through the establishment of a small, working, building committee of not more than three persons (preferably fewer), who will stand between the architect and the hospital staff. The building committee should include the administrator of the hospital. He should see to it that the idiosyncrasies of individuals in such matters as recommended equipment, areas, locations, and arrangement details are not permitted to impose upon proper arrangement with adverse effect on the plan as a whole.

"The hospital consultant can be of inestimable value in preventing such unbalanced arrangements. The employment of a professional consultant is advantageous to the architect since he often finds himself at a disadvantage in arriving at agreements with members of the medical staff.

"Ample time for study should be given in the early stages of planning, in the interest of preventing costly changes and delays during the working drawing stage, or more costly mistakes of the kind not discovered until the new building is in operation. This need for planning time should be made clear to the members of building committees, trustees of the institution, and the public as well."

One aspect of cooperation that is seldom mentioned was suggested by a Chicago architect, who said, "The administrative executives of hospitals should not fail to educate the employees and various personnel to the proper use of the new facilities available in any new building."

The experience of many administrators indicates that proper orientation of personnel in the use of newly provided facilities will eliminate much costly inefficiency in the first weeks of operation.

Fairly unanimous are the expressions as to the most important consideration in the selection of a contractor. These are generally listed as business integrity, financial stability, construction knowledge and experience, organizing ability and detailed knowledge of available sources of labor and materials.

One architect says, "We believe competitive bids are the only means through which a board may be certain it is buying its project at the proper and lowest prices, that is at the market price, except in the case of a private individual or individuals spending their own money. Bidders should be selected by the architect from contractors with whose work he is familiar and whom he knows to possess the essential qualifications—integrity, experience and skill."

Another architect arrives at a similar conclusion as follows: "The most important consideration in the selection of a contractor is his proven ability to produce the high-grade workmanship and material necessary to a satisfactory building; this factor is followed closely by the measure of integrity and financial standing."

The Utility Area as a More Efficient NURSING CARE WORKSHOP

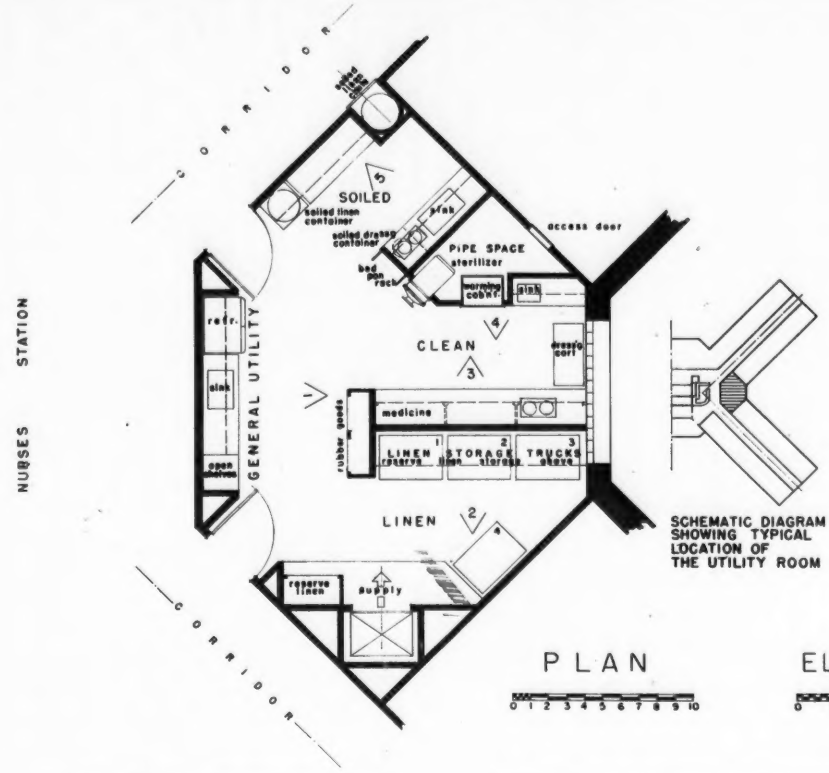
JAMES A. HAMILTON, FACHA
JAMES A. HAMILTON AND ASSOCIATES
HOSPITAL CONSULTANTS, NEW HAVEN, CONN.
AND
DOUGLAS ORR
ARCHITECT

MUCH HAS already been written on the subject of the utility room, but attempts should be continued to improve the type of service rendered by this area of the hospital in order to simplify procedure and to cut down the nurses' steps. It is with this in mind that the present material is submitted as a further endeavor to improve this very vital area of a nursing floor.

The particular plan developed here is for a multi-story hospital with a central core and converging wings. The utility room is placed at the intersection of two wings opposite the nurses' station, and the bedroom wings are so arranged that there is visual control of each wing from the nurses' station. All rooms have toilet units opening out of the room, and on floors which have multi-bed rooms, a treatment room is provided. The nursing unit served by one utility room varies from 26 patients in private rooms to 46 patients in multi-bed rooms.

A very definite advance was made in utility room layout when the various separate utility rooms were grouped into a single room which was divided into two parts; namely, the soiled and clean sides. Some instances occur where the room is divided into more than two parts, but on a somewhat different basis than presented here. This plan divides the utility room into four functional areas, each of which can be entered directly from the focal point of the room.

A general utility area, where most of the activities of this room take place, is conveniently located between doors to each wing so that a nurse can have immediate access to it without going into the other space. Opposite the general utility is the clean area of the room, with the soiled area on one side and the



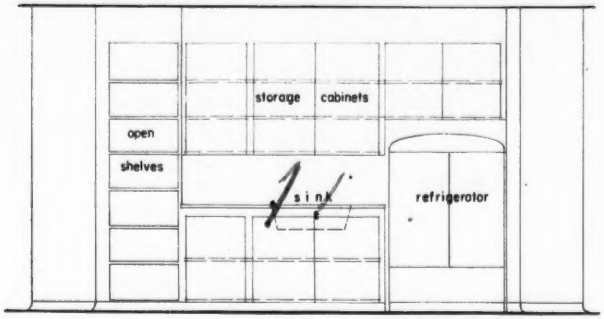
SCHEMATIC DIAGRAM SHOWING TYPICAL LOCATION OF THE UTILITY ROOM

PLAN

0 1 2 3 4 5 6 7 8 9 10

ELEVATIONS

0 1 2 3 4 5



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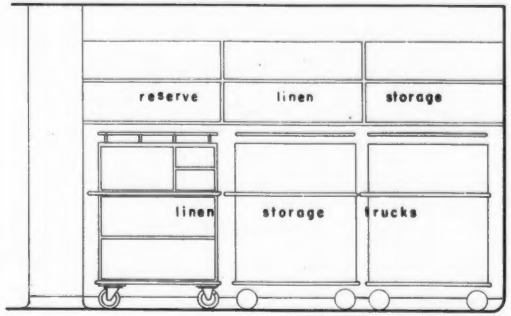

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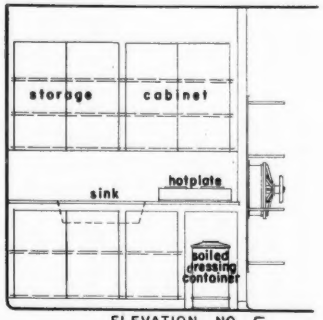

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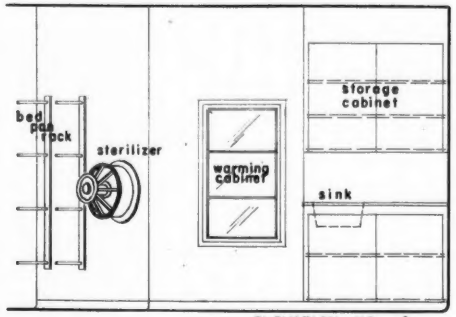

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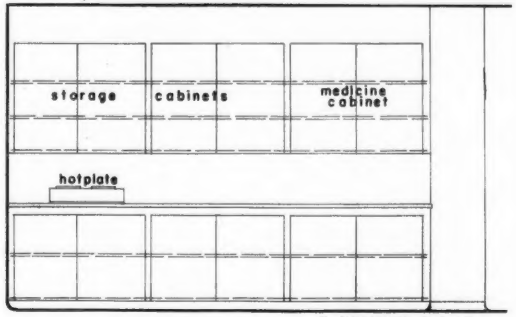
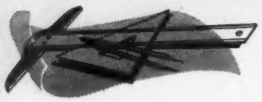


ELEVATION NO. 3

The Utility Room—A Nursing Care Workshop

JAMES A. HAMILTON, Hospital Consultant. DOUGLAS ORR, Architect



linen room area on the other. It seems that this subdivision will greatly simplify the procedure of work in the utility room and will save many nursing steps and furnish much more adequate service to the patient.

In the general utility area will be stored such utensils as pitchers, basins of various types, pails, bottles and general supplies such as compresses, ice bags (in refrigerator unit), mouth washes, rubbing alcohol and the like. Here the nurses will prepare the most frequent treatments which do not require sterile material.

In the clean area will be stored all sterile goods, including solutions, treatment trays, dressings, orthopedic supplies, hypodermics and kindred articles. The medicine station is also in this area. The treatment care will be kept here with a sink and work counter adjacent to it; nearby will be a high pressure sterilizer and a warming cabinet in which solution flasks will be kept.

In the soiled area will be stored such things as douche pans, pitchers, enema cans, sputum cups, specimen boxes and bottles. Included in this area are a sink and work counter. There will be a soiled linen bag to collect individual pieces as they accumulate. Soiled dressings, for example, either will be collected in a can or chuted directly to an incinerator. It should be noted in regard to this area that in this particular case the bed pans will be washed and stored in the toilet units provided off all patient rooms.

Sterilizing will normally be done only following the discharge of each patient. The high pressure sterilizer located between the soiled and clean areas will take a special rack holding several bed pans.

Specimens will be kept in a section of the refrigerator unit and dispatched to the laboratory for analysis, either by a pneumatic tube system in proper container or by a small conveyor system.

The method of handling and storing linen has been studied with the idea that the trucks containing the daily linen supply for each nursing unit will be loaded at the laundry. These trucks would be dispatched to the floor on the regular service elevators and parked in spaces furnished in the linen side of the utility room so that they can be available to be transported to the patient area, as the material is required in the rooms. When the trucks are emptied, the orderly service will return them to the laundry for the next day's loading.

Space for storage of rubber goods and an ample supply of reserve linen for emergency cases is provided. Soiled linen will be either bagged as beds are changed and put down the laundry chute, or accumulated in the utility room in a bag which will go down the chute when full. Individual pieces of laundry are not sent down the chute.

Simplified Handling

The chute will be arranged in such a manner that a bag can easily be slid from the floor into the chute and dispatched to the collecting area. This eliminates the likelihood of soiling the chute itself and simplifies the handling of the soiled linen at the lower level, as the bags are simply picked up and taken to the laundry sorting area.

The subdivision of the utility room into these several areas permits different types of service to be carried on efficiently and without confusion. The room is easily supervised, and we believe that it will function much better than a normal utility room divided into only two parts. When a nurse comes to the utility room, she generally brings something to be disposed of or to be replenished, and she returns from the room with fresh supplies, fresh linen, medication or treatment. It can be easily seen that her course through the utility area in fulfilling these duties is simple, easy and direct.

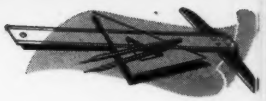
It is further planned to capitalize on the advantages inherent in a vertical type of building and to furnish the same quality of service to the patient via the utility room that is provided by rapid elevator service to the rest of the building and also to eliminate as much orderly service about the building as possible. A good sized dumbwaiter which directly connects all utility rooms with the central supply area will carry all supplies, including medicine, treatment trays, and other items normally dispatched to the nurses' station and which must be taken to the utility room to prepare. Only such cumbersome equipment as oxygen tents or splint racks is excluded, since these must of necessity be carried on the regular service elevators.

It has been argued that to place all supply at this point would require constant supervision of the utility room to control and receive supplies when they arrive. However, the bulk of daily supplies can be handled on a scheduled time basis and an orderly could receive and store supplies, moving from one nursing unit to another. There will be a signal system which, on arrival of the dumbwaiter, will light a light at the nurses' station so located that a nurse may see from either room corridor when material has arrived at the utility room.

An automatic unloading device will deposit supplies at the designated floor and thus leave the dumbwaiter free to return to central supply for another load. This feature would eliminate the argument that if the dumbwaiter is not immediately unloaded, it will block the entire system.

It is our belief that the advantage of having all supplies arrive at a central point more than overcomes incidental objections and that this system will reduce to a great degree the necessity of frequently dispatching orderlies with materials which cannot be carried on the small dumbwaiters usually located at the nurses' station. Such an arrangement should tend to cut down the amount of orderly service required and should speed up the dispatching of all items out of central supply as well as maintain better control.

The purpose of the study presented here is to bring about the development of an area which will be most efficient and will eliminate as far as possible the retracing of steps and the confusion which often exists in a room which is not specifically laid out for each type of operation. We believe that the organization of the four functional areas, the truck method of supplying and storing linen, and the direct supply service for almost all supplies, help in producing a more efficient utility area.



Educational Leadership May Hinge on THE NURSES' RESIDENCE

LUCIUS R. WILSON, M.D., FACHA
MEDICAL CONSULTANT

G. MORRIS WHITESIDE II
ARCHITECT

THE DEVELOPMENT of nursing as a profession in America, during the last few decades, has been so rapid that it has attained a comparable standing with other professional schools in regard to faculty, curriculum, and selection of students. This has been due largely to the energy of educators in nursing, and only recently have the governing boards of hospitals and hospital administrations been awakened to the contribution made by the nursing profession in the care of the sick.

This understanding has caused those hospitals undertaking to operate schools of nursing to set for themselves the task of maintaining adequate teaching facilities including classrooms, laboratories, offices and a library such as colleges offer their students.

The nurses' residence quite often is not only the dormitory home of the students, but contains the educational units as well. Members of the board of managers, nursing educators and hospital administrators are becoming more keenly aware that the school chosen by the prospective student nurses will be the one which offers inviting recreational and living accommodations as well as adequate educational facilities.

The environment which students are invited to share for their three years in training is indicative of the organization's philosophy of education. Recognition that the social life and personal development is of great importance to professional preparation should be reflected in the planning of the nurses' residence and the school of nursing's educational facilities.

It is safe to predict that within the next few years those hospitals which wish to maintain their schools of nursing in the now highly competitive field of nursing education can do so only by providing suitable living and educational facilities. Those hospitals which fail in this respect will soon find themselves with deteriorating schools of nursing, and as a result the nursing service in hospitals will suffer unless some other means are found to provide the care essential to patients now made complex by the rapidly developing medical profession.

The board of directors of the Wilmington General Hospital, fully aware of this condition, in 1928 built a nurses' residence that would meet the requirements of nursing education. At the time it was built adequate educational and living accommodations were provided. Single rooms were planned with bath and toilet facilities for every two students; comfortable, attractive and spacious sitting rooms as well as desirable classrooms and laboratories were included.

With the growth of the hospital and the growth of its school of nursing, the board of directors found that this nurses' residence, which had been so well planned and built, was too small with the inevitable result that two nurses lived in a room built to accommodate one. Solaria that were converted into dormitories and classrooms were crowded. These conditions forcibly brought to the attention of the board the urgent necessity of enlarging the nurses' residence and its educational facilities.

Another unit is to be added to the nurses' residence which will be larger than the original residence, and will provide single bedrooms, with bath and toilet for every two girls, to meet present needs with a number of reserve bedrooms for possible increase in the student enrollment.

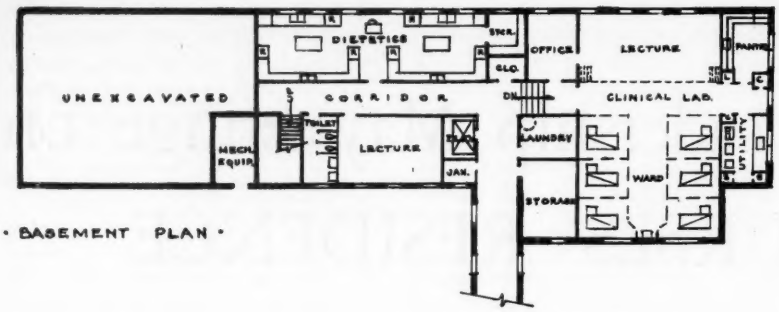
The basement floor of this unit, which will be above ground on three sides due to the contour of the land on which it is located, contains the laboratory for nursing arts complete with lecture room, a ward pantry, utility rooms, nurses' station and linen closet.

By means of folding doors between the lecture room and the laboratory for nursing arts, the entire space may be used as one or two rooms as desired. Every facility is located in this laboratory that will be found on a hospital division where patients are accommodated —even to curtains which can be drawn around a bed to insure privacy for a treatment or an examination of a patient.

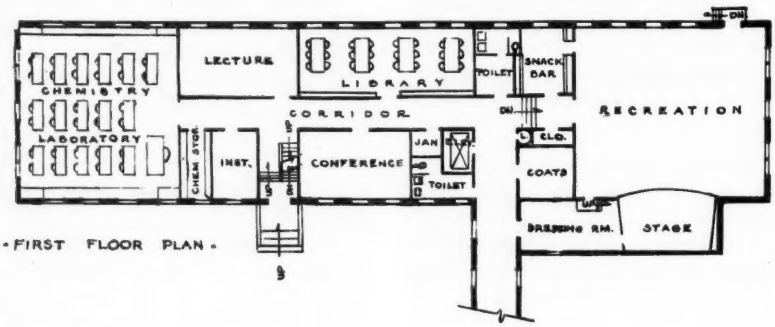
This floor also contains a dietetic laboratory of sufficient proportions to provide working space and instruction for one-half of the estimated number of students admitted in any class. Students will work in pairs and for each pair a complete unit is provided including table space, sink, range, cupboards and all necessary equipment. Across the corridor from the dietetic laboratory is a second classroom.

The first floor provides a chemistry laboratory fully equipped for the use of the entire class with a complete work table and all needed equipment for each two students. The third classroom in this new unit is adjacent to the chemistry laboratory and another room designated as a conference room has been provided which may be used

Dr. Wilson is superintendent of the Hospital of the Protestant Episcopal Church, Philadelphia.



• BASEMENT PLAN •



• FIRST FLOOR PLAN •

as a classroom should occasion arise. The reference library is located on this floor. It has reading tables to accommodate 24 students and book shelves of adequate proportions for several hundred volumes.

The auditorium will accommodate the entire student body and guests. It will be used for general assemblies, capping exercises, graduation and dances. So that its use will be flexible, a dressing room is provided off stage; a pantry is adjacent for serving refreshments; a coat room for guests and men's and women's toilets have been conveniently located.

The first, second and third floors connect by a corridor with the present unit of the nurses' residence. The second, third and fourth floors contain the living accommodations for the students and some of the faculty members. Each student will have a single room, completely furnished, and will share with another student a bathroom thus providing lavatory, bathing and toilet facilities for every two students. The faculty members will have suites of rooms containing a living room, bedroom and bath.

Careful attention has been given to providing adequate closet space for each individual. The second floor contains a large living room with a pantry adjacent for the informal use of the students who do not wish to go to the living room in the residence.

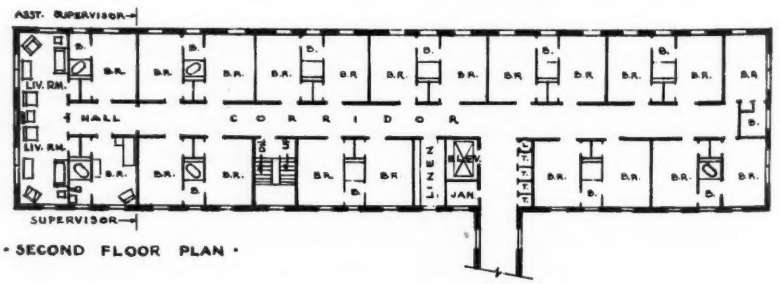
The roof of the building is flat and surrounded by a parapet wall. A pent house is conveniently located on the roof and contains a pantry, toilet facilities and storage space for deck furniture. It is planned to use the roof for parties and dances. During the day it may be used for sun bathing, lounging under deck umbrellas or other recreational activities.

Provisions have not been made in the new addition for spacious living rooms, as those provided in the original building were of such size that duplication was not felt necessary. The same is true of certain classrooms and laboratories not included in the new addition.

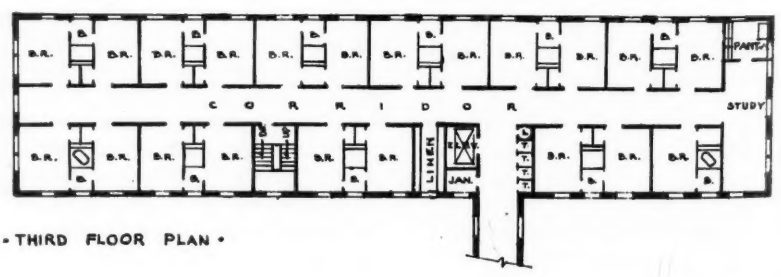
The exterior of the building will be brick matching the other unit. Precast stone will be used for trimming. The window frames will be metal and slate will be used for the window sills. Acoustical treatment will be applied to the ceilings of the classroom and corridors. Cork flooring will generally be used in corridors, classrooms and bedrooms. The wood trim will be birch and the hardware will be white metal. In general, the standard of the materials used will be that which will provide comfort and be durable with the minimum of maintenance.

When the new addition is completed the nurses' residence will accommodate 109 nurses with each one having a single room, thus providing living accommodations, educational and recreational facilities with which students and parents will be happily satisfied. The additional units are adequate and so thoroughly equipped that a sound educational program can be maintained.

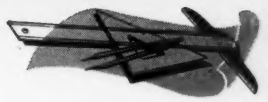
The board of directors has paid careful attention to the selection of the director of nursing and the faculty so that the school of nursing of the hospital will meet all re-



• SECOND FLOOR PLAN •



• THIRD FLOOR PLAN •



quirements in nursing education and will be one of the schools in the United States to maintain its position in the rapidly developing competitive field of nursing education.

W. Samuel Carpenter III, is chairman of the Building Committee of the Board of Directors. Besides this new unit to the nurses' residence, plans are being developed to remodel one wing of the hospital and add a new addition to it to accommodate a new kitchen with necessary storerooms, dining rooms, clinical laboratories, operating rooms, central supply room, and the department of physiotherapy.

When the building program is completed, the hospital will contain all necessary service units so thoroughly equipped that it will satisfactorily meet the service needs of its community.

Basic to Sound Expansion Planning Is the COMMUNITY INVENTORY

ANTHONY J. J. ROURKE, M.D.
SUPERINTENDENT, STANFORD UNIVERSITY HOSPITALS, SAN FRANCISCO

THE TREMENDOUS PROGRAM of hospital expansion now being contemplated throughout the United States emphasizes more than ever before the necessity of taking an inventory of the community and projecting any building expansion on the basis of a well thought out program. The first step in a new community venture is to create sincere interest and abounding enthusiasm for the project. This particular step at the moment is the one which seems to need very little attention from the surveyor.

The second step concerns itself with a community survey and calls for a person experienced in the hospital field. The following thoughts will be concerned entirely with the community survey.

Frequently a survey is initiated by citizens with hospital interest and enthusiasm, and unfortunately at times is requested with the earnest desire – if not a demand – to prove that the enthusiastic ideas of the people asking for the survey are correct. The surveyor who starts his work with preconceived new hospital construction in mind will usually fall far short of his objective, which should be a recommendation *to do or not to do.*

In analyzing a community one must first determine the size of population to be served. This figure should be determined for the entire metropolitan area involved and should also take into consideration a percentage of the surrounding smaller communities. It is very simple to determine the hospital population of the metropolitan area, since this figure is frequently available at the office of the Chamber of Commerce, and because the entire population is involved there is seldom an error in computing this figure.

The percentage of the population in nearby smaller communities is a more perplexing problem since there are so many factors governing the direction taken when medical and hospital care are needed. In some surrounding communities there will be found very small hospital units which might be considered health centers. Such facilities take care of the doctor's need for minor surgery plus uncomplicated obstetrics.

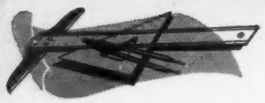
The use of such facilities will be largely dependent upon the skill and success of the local physicians. I have visited almost identical communities and found in one tremendous confidence on the part of the population in its local doctor while in the other the local physician did not stand in high regard and was used only when it was impossible to go elsewhere for medical care in sufficient time. It may readily be seen that two such communities will have opposite effects upon the need for beds in the metropolitan center.

In contrast to this type of surrounding community we find other communities equally as near to the metropolitan center and of the same size with no health facility of any type. Such a community will have a third type of effect on the metropolitan center since not only will the patients needing major surgery find their way to the city but practically every other type of patient needing hospital care will find his way there.

The United States Public Health Service and other authors have outlined the ideal distribution of health centers, intermediate type hospitals and large hospitals. While this is an ideal goal, if one stays in contact with reality it is perfectly evident that such a network of institutions will never exist without sizable federal funds. In such an instance the surveyor is faced with the problem of a metropolitan area planning to build but completely unwilling, and understandably so, to invest any of its funds in a health center in some nearby rural area. It is also evident to the surveyor that such an area will never be able financially to construct or support its own center. The surveyor is then torn between the two points—namely, the ideal and on the other extreme facing reality.

A surveyor working during the next six months or year should keep in mind that certain rural communities have been without physicians and have a larger number of patients gravitating to the metropolitan areas than will be the case when well trained young physicians return to their country practices.

In one western city the author spent considerable time in arriving at what percentage of the surrounding population should be included. After conferring with local physi-



cians to determine the amount of work received, and with rural physicians to determine the number of patients referred, and considering geographical barriers, a figure of 50 per cent of the surrounding population was used as a basis to determine need for hospital beds in the metropolitan hospitals.

The surveyor, in addition to studying population figures, should survey the number and quality of physicians in the area. Of particular importance to him should be the number of trained specialists found in the metropolitan area. The author has found in two western communities patients being referred not only from the surrounding communities, but from the area itself to other centers from two to five hundred miles away, in order to secure the services of a specialist in a given field.

May Find Gaps

If the surveyor takes the past experience of the metropolitan hospitals as his guide, it is possible that he may find, for instance, practically no urology being practiced and if he will look further he will find that there is no trained urologist in the community. It will frequently be evident to him that there are a sufficient number of people in and surrounding the community to warrant the location of a specialist in urology.

Unfortunately it frequently takes the building of a new modern facility to attract specialists and a surveyor should keep this in mind and should plan that every metropolitan area of 15,000 or 20,000 population should have provision for specialists in all the fields.

The major problem in any survey, particularly in those cases where expansion is necessary, will be how many additional beds are needed in the community. In referring to the literature one will find sufficient figures to adequately confuse him and they will run from as low as 2.5 beds per thousand population to 11.1 beds per thousand urban population. Or if one draws upon a more current figure he will see that the experience in our prepaid hospital plans would indicate that provision should be made for an average of over one hospital day per year per member.

It should be realized that where the greatest number of subscribers exist the hospitals in those communities during the past year have been so crowded that certain hospital admissions are delayed or never occur, and that others who are admitted have their hospitalization reduced because of this shortage of beds. Therefore the surveyor will realize immediately that the experience of the past year or so may not be considered as a safe figure to base his recommendations upon. It also must be realized that widespread coverage by prepaid hospital insurance may lead to a hospital utilization that at the present time cannot be visualized.

When one considers that in 1935, 36.9 per cent of the babies born in the United States were born in hospitals and that this figure had risen in 1943 to 72.1 per cent, it is evident in the field of obstetrics that birth in the hospital is becoming more popular each year. The surveyor, however, can never take national averages and apply them to local communities, which is adequately demonstrated by the fact that in Mississippi 15.8 per cent of all births occurred in hospitals while the figure in Connecticut rose to 89.4 per cent. The surveyor should constantly keep in mind what state he is working in and particularly what city within that state. Local experience and custom must be given considerable weight in the final decision.

Another trend which must be taken into consideration in all hospital surveys is the increase in the expectation of life at birth. Figures quoted by the Metropolitan Life Insurance Company indicate that in the decade between 1879 and 1889 the expectation at birth was 34 years, while in 1944 this figure had jumped to 64.4. We must keep in mind that with this increase in the expectation of life, many of the children who have been able to survive diabetes, diphtheria and whooping cough will now live long enough to develop gallstones, kidney stones and heart disease. The ultimate effect on hospitalization of this increased longevity has not yet been realized.

It should also be borne in mind that we will have a greatly increased pediatric problem, because of the increased birth rate which has every indication of remaining high. The need for pediatric facilities will be greater during the next 10 to 15 years than ever before. With this in mind every surveyor should try to determine in his own mind the age of the community. This is perhaps best done by consulting the school departments and cataloging information regarding the number of children in each grade in the school system.

Should Be Objective

One of the most important points for a successful survey is that the surveyor remain completely objective during his work and that he make it clear to all people securing his services that he will study the problem and give an honest opinion even though that opinion may be unfavorably received by those people financing his services. If such an agreement cannot be reached the survey work should not be accepted. It is very well during the field work of a survey not to come to any conclusions but to continuously collect opinions, statistics, information and the like. The written report and recommendations are best prepared after the surveyor leaves the community and returns to his home office.

No survey is complete unless every possible source of information and opinion is sought. A few sources of such information are suggested but not in any way to indicate that this list is complete or to eliminate the fact that in certain communities there may be particular sources of information which do not exist in others. The author has found that in a survey, if the hospital facilities are left until the last, the survey of that particular portion of the community has been more revealing if prior contacts are made with the chamber of commerce, department of education, state hospital survey committees, visiting nurse association, county dental society, county medical society, health officer, service clubs, banking interests, church groups, state hospital association and regional or local public health service.

It is well, where sufficient time is available and the community is not too large, for the surveyor to visit all patients being hospitalized. At times it is revealing to find that a certain percentage of the patients represent chronic and long-term convalescent cases. Such a fact should not influence the building of acute hospital beds for such members of the community. If this percentage is large enough and if the community is large enough, considerable thought should be given to separate wings for this type of care.

Interest Is Stimulated

Frequently community interest and enthusiasm are stimulated as a manifestation of dissatisfaction with existing services. Such dissatisfaction at the present time may be caused by more than one factor—first, and the one which I am sure is in the mind of every hospital administrator at the moment, would be the result of those factors beyond our control: scarcity of personnel and supplies which prevented us from rendering the highest grade hospital service possible.

It is the duty of every surveyor to point out this particular factor to the community and the author knows no better way than to relate to the local community the problems the surveyor has found in his own hospital and in other communities which he has surveyed. Complaints based upon this particular factor are in no way justification for large expenditures of money in establishing new competitive institutions.

All too frequently today dissatisfaction is caused by antiquated hospital facilities. This particular matter calls for a *replacement* rather than an *expansion* program. It is especially interesting at the moment to find how inadequate certain of the central services are and how, because of bed expansion within an existing building, such central space has been squeezed down to an inadequate minimum. I have had the opportunity to see operating rooms still functioning in hospital wings more than 60 years old. During that period of time poorly planned patch types of improvements were made in the existing operating rooms with the result that only major renovations would now be financially advisable in such ancient structures.

Such inadequate operating facilities may tend to focus the attention of surgeons on other inadequacies but their inability to see the entire picture may unconsciously project their dissatisfaction to the entire service. It is my candid opinion that at the moment we need nearly as much replacement of hospital facilities as we do hospital expansion.

Medical staff organization has in many instances become a war casualty. This inevitably leads to discord and dissatisfaction, which may find its outlet in unjust criticism of hospital service. Every hospital needs a strong united staff to do its best job. The surveyor at times occupies an enviable position in evaluating such problems and recommending solutions.

Over-hospitalization should haunt every surveyor. Now is the time for the expert to hold the community down to a reasonable program. Local optimism and local pride all too often cause a community to prophesy tremendous postwar growth of population and industry. I have experienced the same optimism in three widely separated communities.

Where Advantage Lies

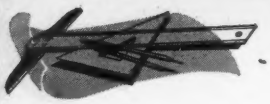
The existence of three or four small hospitals in a city at the present time should impress every surveyor with the importance of pointing out to the community the advantages of larger hospitals. It becomes evident that new hospitals have been built in the past to satisfy personal desires of small groups.

To summarize—the survey should be objective, hospital population should be determined, the quality of medical staff evaluated, changing trends considered, all sources of information explored, replacement should not be confused with expansion, convalescent and chronic need should be measured, dissatisfaction with existing facilities weighed and the advantages of size outlined.

A QUALIFIED ARCHITECT
Will Help to Prevent Waste and Confusion

THE CONSTRUCTION of a hospital is dependent upon proper planning, and in this light it is essential that an administrator faced with the responsibilities of spending large sums of contributed money have associated with him an architect who can understand the correlation and functioning of the interrelated departments. This knowledge can only be gained from years of experience in designing similar institutions. The architect must be able to grasp the significance of a qualified administrator's ideas and lean toward the practical rather than the aesthetic side. The hospital can and must function as a coordinated institution rather than a creation of inexperienced planning. Too many times in the past, administrators have been embarrassed and chagrined to be compelled to become associated with the local architect, who has not by training and experience been able to realize that the designing of a hospital is 90 per cent functional and 10 per cent architectural engineering.

It is not sufficient that an architect be familiar with the primary plans and general rules of architecture, but also necessary that he be conversant in the more intimate details of hospital construction. The American Hospital Association has an increased responsibility to its membership to aid and assist them in any problems related to hospital administration, and in the establishing of the Hospital Architects Qualifications Committee, they are merely following the precedent set by other organizations which provide similar advice and counsel to their respective memberships. — GEORGE D. SHEATS, *administrator, Baptist Memorial Hospital, Memphis.*



Initial Roster of Hospital Architects APPROVED BY ASSOCIATION

THE ROSTER of hospital architects approved by the American Hospital Association is herewith presented in its initial form. This roster has been compiled after study of the individual architect's qualifications by the Association's Hospital Architects Qualifications Committee. The exceptions to this procedure are the architects whose interest in hospital design had prompted them to seek membership in the Association before adoption of the program early in 1945.

The roster has been created in accordance with a program adopted by the American Hospital Association which reads in part:

"In furtherance of its aim to promote the sound designing of hospitals and to facilitate the selection of specialized architectural talent and counsel for the many hospitals in the United States and Canada, the American Hospital Association will:

"Extend to architects of proficiency in hospital design and good standing in their community an invitation to become associate personal members;

"Will promote the general practice of engaging hospital architects of established qualifications for the design of hospitals or as consulting architects to supplement the services of architects lacking specialized knowledge of hospital requirements;

"It is the basic intention of this program to admit to membership the largest possible number of qualified architects. The qualifying procedure will give recognition to every architect able to demonstrate his

ROSTER OF HOSPITAL ARCHITECTS APPROVED BY THE AMERICAN HOSPITAL ASSOCIATION

Francis V. Bulfinch—Coolidge, Shepley, Bulfinch and Abbott, 122 Ames Building, Boston.

Charles Butler—Charles Butler, Robert D. Kohn and Addison Erdman, 56 W. 45th Street, New York 19, N. Y.

Charles Crane—Crane and Stephens, 415 Lexington Avenue, New York 17, N. Y.

Thomas H. Creighton—43 Hamilton Place, Douglaston, N. Y.

Carl deMoll — The Ballinger Company, 105 S. 12th Street, Philadelphia 7.

Roscoe P. DeWitt—406-7 Gulf States Building, Dallas 1, Texas.

Harry Duckworth — 711 Linden Street, Scranton, Pa.

James R. Edmunds Jr.—409 Calvert Building, Baltimore 2.

Thomas F. Ellerbe—Ellerbe and Company, E1021 First National Bank Building, St. Paul 1, Minn.

Carl A. Erikson—Schmidt, Garden and Erikson, 104 S. Michigan Avenue, Chicago 3.

G. Corner Fenhagen — Buckler and Fenhagen, 325 N. Charles Street, Baltimore 1.

Arthur A. Fisher—Fisher and Fisher, 827 Denver National Building, Denver 2.

Fred R. Hammond — Jamieson and Spearl, 1696 Arcade Building, St. Louis 1.

H. Eldridge Hannaford — Samuel Hannaford and Sons, 1024 Dixie Terminal Building, Cincinnati 2.

George S. Holdernness—Eggers and Higgins, 542 5th Avenue, New York 19, N. Y.

Myron Hunt—Myron Hunt and H. C. Chambers, 124 W. 4th Street, Los Angeles 13.

W. P. Johnson—Meyers and Johnson, Commerce Building, Erie, Pa.

William Kaelber—Wm. G. Kaelber & L. A. Waasdorp, 311 Alexander Street, Rochester 7, N. Y.

Arthur S. Keene—Keene & Simpson, 15 W. 10th Street, Kansas City 6, Mo.

Frank Latenser — John Latenser & Sons, 1307 Farnam Street, Omaha 2, Neb.

Joseph D. Leland—Leland and Larsen, 814 Statler Building, Boston.

L. H. Lewis—Crow, Lewis & Wick, 200 Fifth Avenue, New York 10, N. Y.

Edgar Martin—616 S. Michigan Avenue, Chicago 5.

Charles Noble — 4484 Cass Avenue, Detroit 1.

George F. Ramey—919 W. University Avenue, Champaign, Ill.

Robert J. Reiley — 45 West 45th Street, New York 19, N. Y.

Richard Resler — Medical Center, Jersey City 4, N. J.

William A. Riley—Curtin and Riley, 45 Newbury Street, Boston 16.

Frank Ellis Rogers—Kendall, Taylor & Co., Inc., 221 Columbus Avenue, Boston 16.

Isadore Rosenfield—10 West 44th Street, New York, N. Y.

Lewis J. Sarvis—206 McCamly Building, Battle Creek, Mich.

Marshall Shaffer—Senior Architect, Hospital Facilities Section, U. S. Public Health Service, Washington 14, D. C.

Henry R. Shepley—Coolidge, Shepley, Bulfinch and Abbott, 122 Ames Building, Boston 8.

George Spearl—Jamieson and Spearl, 1696 Arcade Building, St. Louis 1.

Robert Stanton—Pebble Beach, California.

Edward Stotz—801 Bessemer Building, Pittsburgh.

Perry W. Swern — Perry W. Swern and Associates, 19 South LaSalle Street, Chicago 3.

Harold P. VanArsdall—Samuel Hannaford and Sons, 1024 Dixie Terminal Building, Cincinnati 2.

Leonard A. Waasdorp — Wm. G. Kaelber & L. A. Waasdorp, 311 Alexander Street, Rochester 7, N. Y.

Chester C. Woods — Confederation Life Building, 12 Richmond Street, Toronto, Ontario, Canada.

proficiency in the field of hospital design and construction."

While the creation of the mechanical details of qualification has limited the number of applications which might be sought up to this time, it is the Association's intention, in accordance with the preceding paragraph, to develop as rapidly as possible a more extensive list that will provide better geographical distribution and recognize a great many more architects who have carried to successful completion plans for the three hospitals that are a prerequisite of qualification.

The policy provides that the chairman of the Qualifications Committee shall be, ex officio, the chairman of the Council on Hospital Planning and Plant Operation and that, in addition, the committee members shall consist of four active hospital administrators and four hospital architects who are members of the American Hospital Association. These committee members are appointed by the president of the Association, who in his selection of the architectural component is guided by nomination made by the president of the American Institute of Architects. The present composition of the committee is as follows:

Albert W. Snoke, M.D., Grace-New Haven Hospital, New Haven, Conn., *chairman.* Frank R. Bradley, M.D., Barnes Hospital, St. Louis; Francis V. Bulfinch, Boston; Carl A. Erikson, Chicago; H. Eldridge Hannaford, Cincinnati; George D. Sheats, Baptist Memorial Hospital, Memphis; Herman Smith, M.D., Michael Reese Hospital, Chicago; George Spearl, St. Louis; Lucius R. Wilson, M.D., Hospital of the Protestant Episcopal Church, Philadelphia.

Because the extent of the current roster obviously is not sufficient to serve the needs of all hospitals that require architectural services, their attention is specifically directed to the phrase in the policy that recommends the employment of a qualified hospital architect as consulting architect to supplement the services of an architect not familiar with hospital requirements. For the hospital that cannot secure the services of an approved hospital architect, some aid in arriving at a selection can be gained from the study of the article, "How to Select an Architect," elsewhere in this issue.

In referring to the roster presented herewith, it should be realized that, because the program is in its early stages, many architects who have successfully carried through the construction of hospitals have not had an opportunity to submit their credentials for approval under this program.

Basing the Blueprints on ADEQUATE DATA

ARCHITECTS, who in preponderant numbers agree that hospital design is more complicated than other types of work involving equal cost, are also in agreement that a major source of this difficulty arises from a lack of basic data for architectural guidance.

Authority for this statement arises out of a survey conducted by the Council on Hospital Planning and Plant Operation for.. HOSPITALS, in which 116 architects familiar with hospital work participated. Most architects believe the lack of planning aids to be especially pronounced for adjunct and service areas.

This expression of opinion confirms the belief that prompted the creation of the Committee on Hospital Facilities of the Council on Hospital Planning and Plant Operation. The adjunct and service facilities of a hospital are the ones to which this committee will devote its major attention. These areas of the hospital have not heretofore been the center of the intensive study that has been devoted to patient areas, surgical suites, and newborn nurseries.

Questioned on their attitude toward the erection of non-fireproof hospitals, 19 per cent of the 116 architects indicated that under some conditions they would consider the design of a hospital of more than one story of other than fireproof construction, while 21.5 per cent emphatically indicated that under no conditions would they design non-fireproof hospital buildings.

This article has been prepared for the Council on Hospital Planning and Plant Operation by Roy Hudenburg, council secretary.

Questioned on the degree of complexity of hospital planning only five architects of 112 indicated that in their estimation hospital design was handled with hardly more study than any job involving equal costs, while 52 of the answers indicated an opinion that a number of other types of work are equally as complicated as hospital structures; 55 of the answers expressed the opinion that hospital planning is more complicated than almost any other type of architectural design.

The hospital area that the greatest number of architects find trouble in planning is that involving x-ray and laboratory provisions. The area which architects feel they could design with more ease if more basic data were available is that embracing pharmacies, sterilizing facilities and central supply rooms.

Forty-eight architects marked the x-ray and laboratory provisions are being troublesome in design, while 50 expressed a need for more basic data. While 51 architects expressed the belief that planning aids for pharmacy, sterilizing and central supply facilities would aid them in their work, only 37 marked this area as troublesome.

The facilities found by the next greatest number of architects to be troublesome in design were those involving utility rooms, pantries and similar nursing provisions; these were found troublesome by 27 architects and by 32 architects as subjects on which more data would be helpful.

Dietary provisions were a source of difficulty for 39, but only 25 believed that additional data would help solve the problem.

Surgical suites were a source of

planning concern mentioned by 26 architects, while 27 saw a need for planning aids.

More recommended standards for newborn nurseries were felt desirable by 19 architects, while only 13 felt this area particularly troublesome. Last on the list were patient areas, which nine architects found a source of planning difficulty, and only seven believed that study needed be given to create more guiding data.

Because the last five years have seen substantial developments in the methods and materials that go into hospital structures, and because little information has become available on the practicability of adapting these improvements for incorporation into hospital building, the architects were requested to name what they believed to be the most significant features in this technological advancement.

Air Conditioning First

Air conditioning was mentioned most frequently as the subject which the hospital administrator should request the architect to investigate in order that the use of outmoded materials or equipment might be avoided.

Of the 116 architects, 42 specifically listed air conditioning, and of this number, one referred to the sterilization of air in this connection, while three specifically referred to electrical precipitation dust filters. Twenty-eight architects were specifically interested in the current advances in methods of heat distribution; 15 called particular attention to the possibilities of radiant heating.

In 25 of the answers, lighting was mentioned as a subject which should be given specific study. Ultra-violet sterilization lamps; sound-absorbing ceilings; simplified, pre-fabricated lighting and hardware units; electric cooking; oxygen distribution, and improved paints and floor finishes were among other items that architects believed should be given study in connection with hospital projects.

Seven of the architects stressed a need for studying explosion hazards when operating rooms are being planned. Several of this number referred to conductive floor coverings for the surgical suites.

Anyone who has been disturbed in the night by the echoing click of the switch will appreciate the suggestion of one architect for the use of mercoid light switches, which are silent in operation, in patient areas. Another suggestion referred to lighter and movable partitions, particularly for laboratory and adjunct facility areas where space requirements may vary during the life of the building.

Items of a less current nature that the architects thought called for special study included: Orientation of the hospital to provide south exposures for patient areas; a trend toward low structures; the advantages of corridors with bedrooms on one side only; and the provision of balconies in front of bedrooms. These particular subjects are being given study at this time by numerous architects, but at the same time are the subject of substantial differences of opinion.

Other pertinent suggestions which are not particularly related to recent improvements included: Elimination of steps at the hospital's main entrance, adequate provision for access to piping systems, and careful study of equipment for food distribution. One architect called attention to the need for investigating possible provisions for community diagnostic centers, and community or municipal health centers in the hospital.

Further emphasis on the importance of providing more help to the architect in connection with adjunct facilities is noted in the fact that 14 answers indicated that the architect should be particularly instructed to study layouts and equipment for laboratory and x-ray departments and five answers put similar stress on the study of the central surgical supply system.

A tabular summary of the various answers to the question "Under what conditions, if any, would you acquiesce to the design of a hospital structure providing less than totally fireproof construction?" follows:

Condition	*No.*	*Per cent*
Under no conditions	25	21.5
If limited to one-story and with special precautions	26	22.4
One-story	28	24.2
If limited to two-stories with special precautions	11	9.5
Under economic stress of community	9	7.8
Temporary low structure	12	10.3
Only after careful study	2	1.7
No answer	3	2.6
Total	116	100.00

The special precautions recommended for inclusion in one story buildings included variously the following provisions: The building be divided by firewalls and firedoors; the building be equipped with sprinkler system; exits be provided so that at least two would serve each area of the building; the heating plant, kitchen, incinerator and similar mechanical rooms be housed in a separate fireproof structure, and the building be constructed either without a basement or with a concrete slab for the first floor if a basement is to be provided.

Shows Strong Feeling

The strong feeling of those who opposed any type of non-fireproof hospital construction is typified by the architect who answered that he would design a hospital structure other than totally fireproof, only if "steel were entirely unavailable, as in China or Burma."

Recognizing the need for typical layouts and other planning guidance, as revealed in this survey, the Hospital Facilities Section of the U. S. Public Health Service has for more than five years been working on such material. Marshall Shaffer, senior architect of the section, has carried forward the development of these standards. His recommended layouts and analysis of space requirements were first printed in HOSPITALS in July, 1943. This material has been reprinted and subsequently widely used as reference data.

Since that time recommendations for a great many more areas of the hospital have been developed by Mr. Schaffer and his staff. Many of these layouts are being reproduced through the cooperation of the U. S. Public Health Service, in the following section of this journal. They should prove to be of substantial value in helping to fill the gap so pointedly emphasized by the architects who participated in this survey.

ELEMENTS OF THE GENERAL HOSPITAL

HOSPITAL FACILITIES SECTION

U. S. PUBLIC HEALTH SERVICE

Federal Security Agency

LIST OF DETAIL DRAWINGS

Hospital Facilities Section, United States Public Health Service

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ELEMENTS OF THE GENERAL HOSPITAL

GEORGE BUGBEE
EXECUTIVE DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

A GREAT DEAL of emphasis has recently been directed towards the building of new hospitals, health centers and allied facilities. This trend is evidenced by the constant stream of letters from urban and rural communities in the United States and foreign countries requesting technical assistance from the American Hospital Association and U. S. Public Health Service. In the past, the Hospital Facilities Section of the U. S. Public Health Service has prepared for public distribution suggested plans for hospitals of various sizes, and for hospital units, health centers and allied health facilities. However due to a wide variety of demand for elements of the general hospital, the need for a more convenient planning guide containing hospital room details has become apparent.

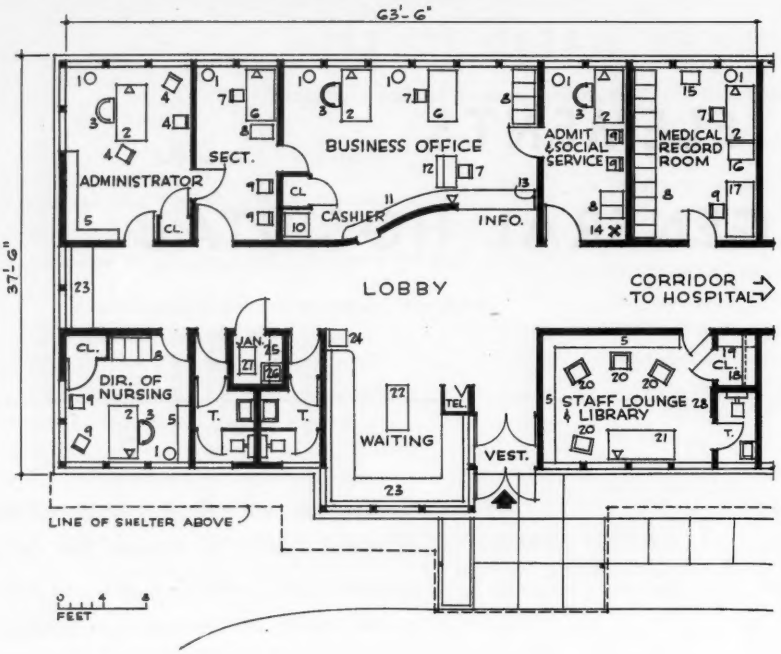
The physical requirements of hospital structures have changed extensively during recent years. Development of new diagnostic and therapeutic methods has brought about the need for new facilities and new equipment. Broader concepts of both public health and hospital service are exerting an influence on hospital design. Improved methods of hospital administration have created new problems to be solved through modern construction. New construction materials and advances in construction design have resulted in basic revisions of building plans.

In keeping with these advances, the Hospital Facilities Section has conducted a comprehensive study of hospitals' needs as the basis for a planning guide consisting of a series of designs covering 80 units and combinations of facilities for a wide variety of health services.

In order to determine the most modern trends in hospital and health facility design, innumerable consultations were held with doctors, nurses, hospital consultants, dietitians, hospital architects, hospital administrators, technicians, manufacturers, and officers of the U. S. Public Health Service and other agencies. The Public Health Service wishes to acknowledge its debt to the above group. The American Hospital Association is equally indebted to the Public Health Service for its leadership in assembling the authoritative information necessary to produce such a series as this, the most complete of its kind.

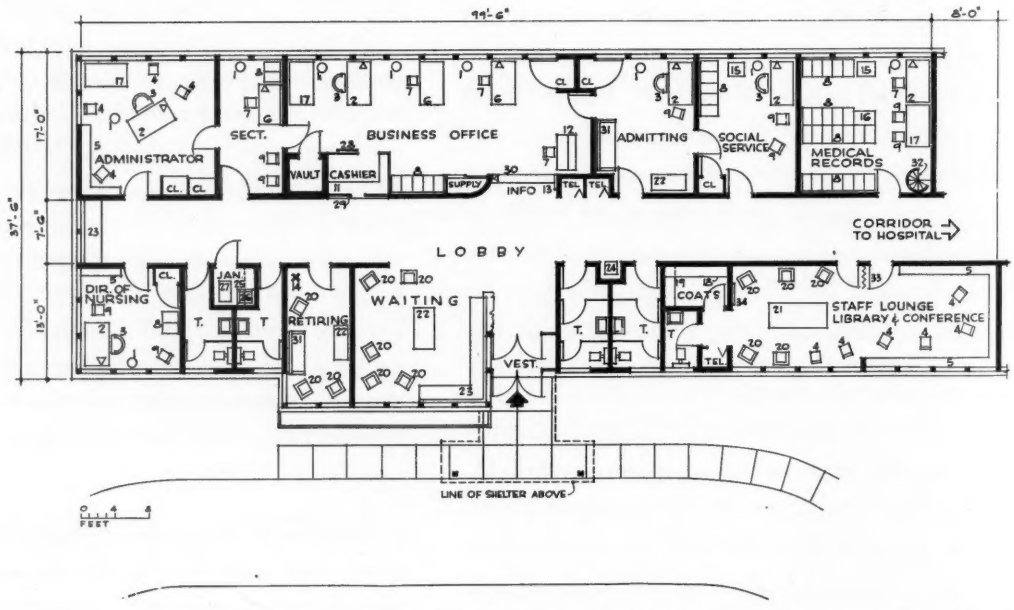
Included in the series are plans for general hospital units such as adjunct diagnostic facilities, administrative, nursing, nursery, surgical, obstetrics, emergency, service and outpatient departments. While the details represent an effort to present a schematic approach to major hospital elements, the U. S. Public Health Service points out that the plans must be altered and adapted to specific problems encountered in the design of any individual hospital.

ADMINISTRATION DEPARTMENT



1. Waste paper receptacle
2. Executive-type desk
3. Executive-type chair
4. Straight chair, upholstered
5. Built-in bookshelves
6. Typist's desk
7. Typist's chair
8. Filing cabinet
9. Straight chair
10. Safe
11. Counter, 40 inches high, cash drawer, with cabinets and drawers below
12. Telephone switchboard
13. Doctors' in-and-out register
14. Costumer
15. Typewriter table
16. Card index file
17. Table, 34 x 60 inches
18. Hat shelf with clothes rod below
19. Shelf, 2 feet above floor
20. Easy chair
21. Conference table
22. Table
23. Built-in bench
24. Water cooler
25. Shelf
26. Janitor's service sink
27. Mop truck
28. Bulletin board, 26 x 24 inches

1—Administration Suite for a 50-Bed General Hospital



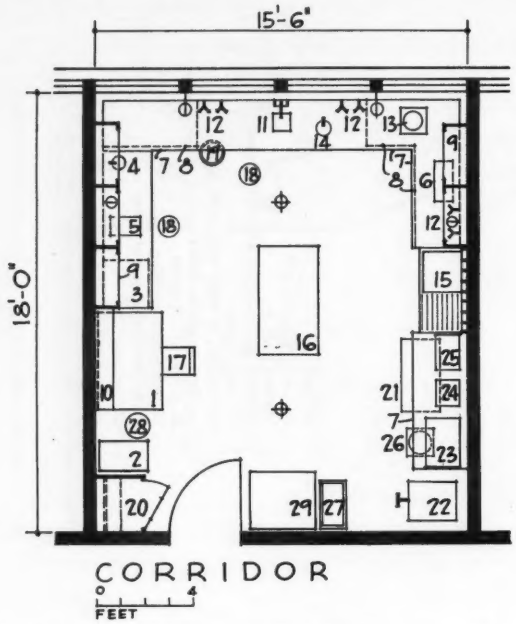
2—Administration Suite for a 100-Bed General Hospital

1. Waste paper receptacle
2. Executive-type desk
3. Executive-type chair
4. Straight chair, upholstered
5. Built-in bookshelves
6. Typist's desk
7. Typist's chair
8. Filing cabinet
9. Straight chair
11. Counter, 40 inches high, cash drawer, with cabinets and drawers below
12. Telephone switchboard
13. Doctors' in-and-out register
14. Costumer
15. Typewriter table
16. Card index file
17. Table, 34 x 60 inches
18. Hat shelf with clothes rod below
19. Shelf, 2 feet above floor
20. Easy chair
21. Conference table
22. Table
23. Built-in bench
24. Water cooler
25. Shelf
26. Janitor's service sink
27. Mop truck
28. Wire mesh partition with sliding gate
29. Glass screen
30. Counter, 48 inches high, open below
31. Three passenger settee
32. Spiral stairway down to dead record room
33. Collapsible partition
34. Bulletin board, 26 x 24 inches

3—*Administration Suite for a 200-Bed General Hospital*

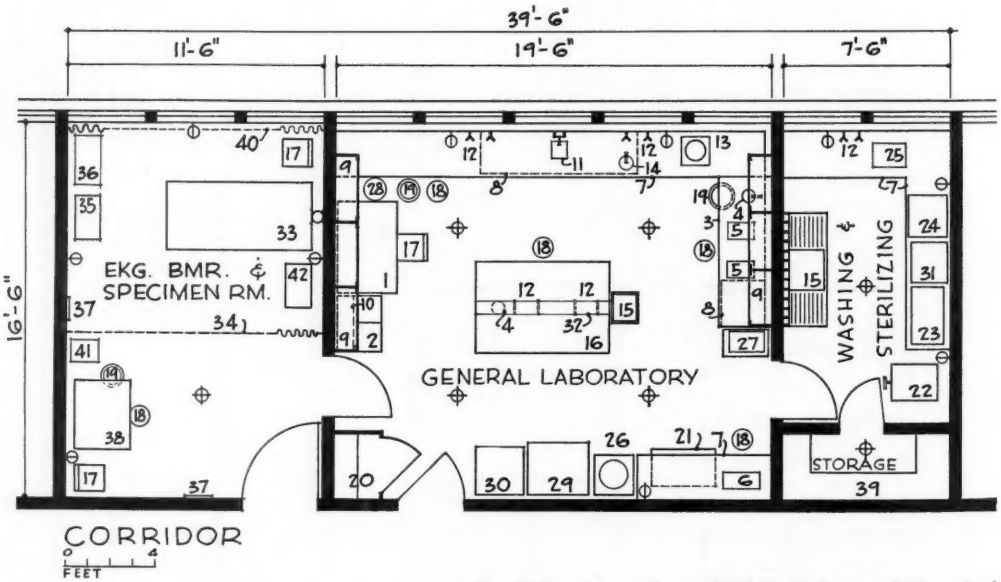
1. Waste paper receptacle
2. Executive-type desk
3. Executive-type chair
4. Straight chair, upholstered
5. Built-in bookshelves
6. Typist's desk
7. Typist's chair
8. Filing cabinet
9. Straight chair
11. Counter, 40 inches high, cash drawer, with cabinets and drawers below
12. Telephone switchboard
13. Doctors' in-and-out register
14. Costumer
15. Typewriter table
16. Card index file
17. Table, 34 x 60 inches
18. Hat shelf with clothes rod below
19. Shelf, 2 feet above floor
20. Easy chair
21. Conference table
22. Table
23. Built-in bench
24. Water cooler
25. Shelf
26. Janitor's service sink
27. Mop truck
28. Wire mesh partition with sliding gate
29. Glass screen
30. Counter, 48 inches high, open below
31. Three passenger settee
32. Table, 34 x 72 inches
33. Collapsible partition
34. Bulletin board, 26 x 24 inches
35. Bookcase
36. Translucent glazing
37. Counter, lift top and gate front

ADJUNCT DIAGNOSTIC AND TREATMENT FACILITIES



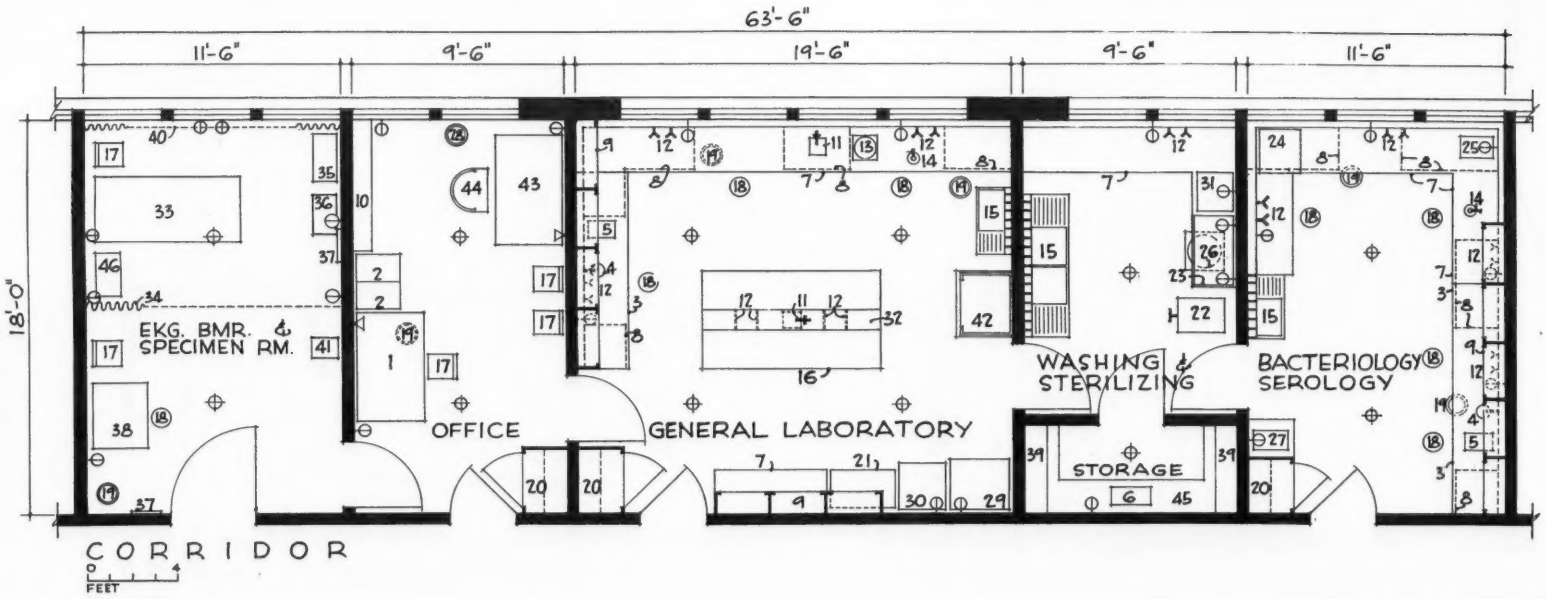
4—Laboratory for a 50-Bed General Hospital

1. Desk
2. Filing cabinet
3. Microscope table, 30 inches high, with cabinets and slide drawers below
4. Cup sink with gooseneck spout
5. Microscope
6. Analytical balance with weights
7. Acid resisting counter, 36 inches high
8. Cabinets below counter
9. Wall cabinets
10. Book shelves
11. Acid resisting laboratory sink with gooseneck spout
12. Air, gas and electric outlets
13. Single element hot plate
14. Bunsen burner
15. Acid resisting laboratory sink with peg boards
16. Table, 30 x 54 inches
17. Straight chair
18. Stool
19. Sanitary waste receptacle
20. Closet
21. Wheel cart for frozen sections
22. Laboratory autoclave, 16 x 24 inches
23. Hot air sterilizer, 18 x 14 x 14 inches
24. Incubator, 12 x 12 x 12 inches
25. Water bath
26. Centrifuge
27. Shaking machine on stand
28. Waste paper receptacle
29. Refrigerator, 8 cubic feet



5—Laboratory for a 100-Bed General Hospital

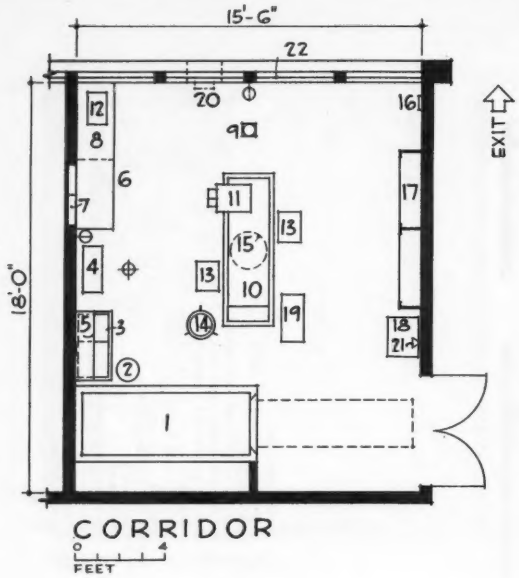
1. Desk
2. Filing cabinet
3. Microscope table, 30 inches high, with cabinets and slide drawers below
4. Cup sink with gooseneck spout
5. Microscope
6. Analytical balance with weights
7. Acid resisting counter, 36 inches high
8. Cabinets below counter
9. Wall cabinets
10. Book shelves
11. Acid resisting laboratory sink with gooseneck spout
12. Air, gas and electric outlets
13. Single element hot plate
14. Bunsen burner
15. Acid resisting laboratory sink with peg boards
16. Chemistry table
17. Straight chair
18. Stool
19. Sanitary waste receptacle
20. Closet
21. Wheel cart for frozen sections
22. Laboratory autoclave, 16 x 24 inches
23. Hot air sterilizer, 24 x 14 x 14 inches
24. Incubator, 19 x 16 x 14 inches
25. Water bath
26. Centrifuge
27. Shaking machine on stand
28. Waste paper receptacle
29. Refrigerator, 8 cubic feet
30. Refrigerator, 6 cubic feet
31. Arnold sterilizer
32. Shelves over chemistry table
33. Hospital bed
34. Cubicle curtain rod and curtain
35. Basal metabolism apparatus
36. Electrocardiograph apparatus
37. Hook strip
38. Table, 30 x 36 inches
39. Shelving
40. Sliding window curtain
41. Adult scale
42. Bedside table



6—Laboratory for a 200-Bed General Hospital

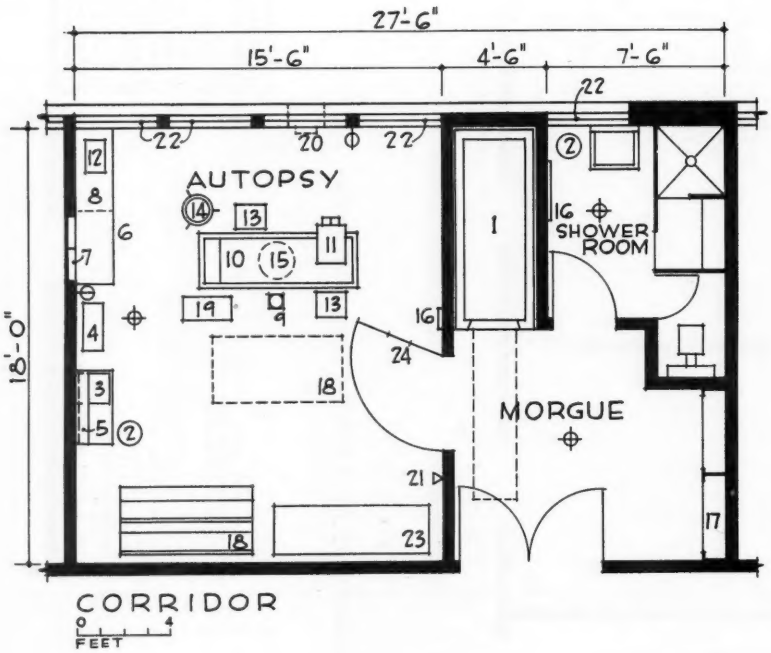
1. Desk
2. Filing cabinet
3. Microscope table, 30 inches high, with cabinets and slide drawers below
4. Cup sink with gooseneck spout
5. Microscope
6. Analytical balance with weights
7. Acid resisting counter, 36 inches high
8. Cabinets below counter
9. Wall cabinets
10. Book shelves
11. Acid resisting laboratory sink with gooseneck spout
12. Air, gas and electric outlets
13. Single element hot plate
14. Bunsen burner
15. Acid resisting laboratory sink with peg boards
16. Chemistry table
17. Straight chair
18. Stool
19. Sanitary waste receptacle
20. Closet
21. Wheel cart for frozen sections
22. Laboratory autoclave, 16 x 24 inches
23. Hot air sterilizer, 30 x 24 x 18 inches
24. Incubator, 28 x 18 x 20 inches
25. Water bath
26. Centrifuge
27. Shaking machine on stand
28. Waste paper receptacle
29. Refrigerator, 8 cubic feet
30. Refrigerator, 6 cubic feet
31. Arnold sterilizer
32. Shelves over chemistry table
33. Hospital bed
34. Cubicle curtain rod and curtain
35. Basal metabolism apparatus
36. Electrocardiograph apparatus
37. Hook strip
38. Table, 30 x 36 inches
39. Shelving
40. Sliding window curtain
41. Adult scale
42. Fume hood
43. Executive-type desk
44. Executive-type chair
45. Counter, 36 inches high, cabinets below
46. Bedside table

ADJUNCT DIAGNOSTIC AND TREATMENT FACILITIES



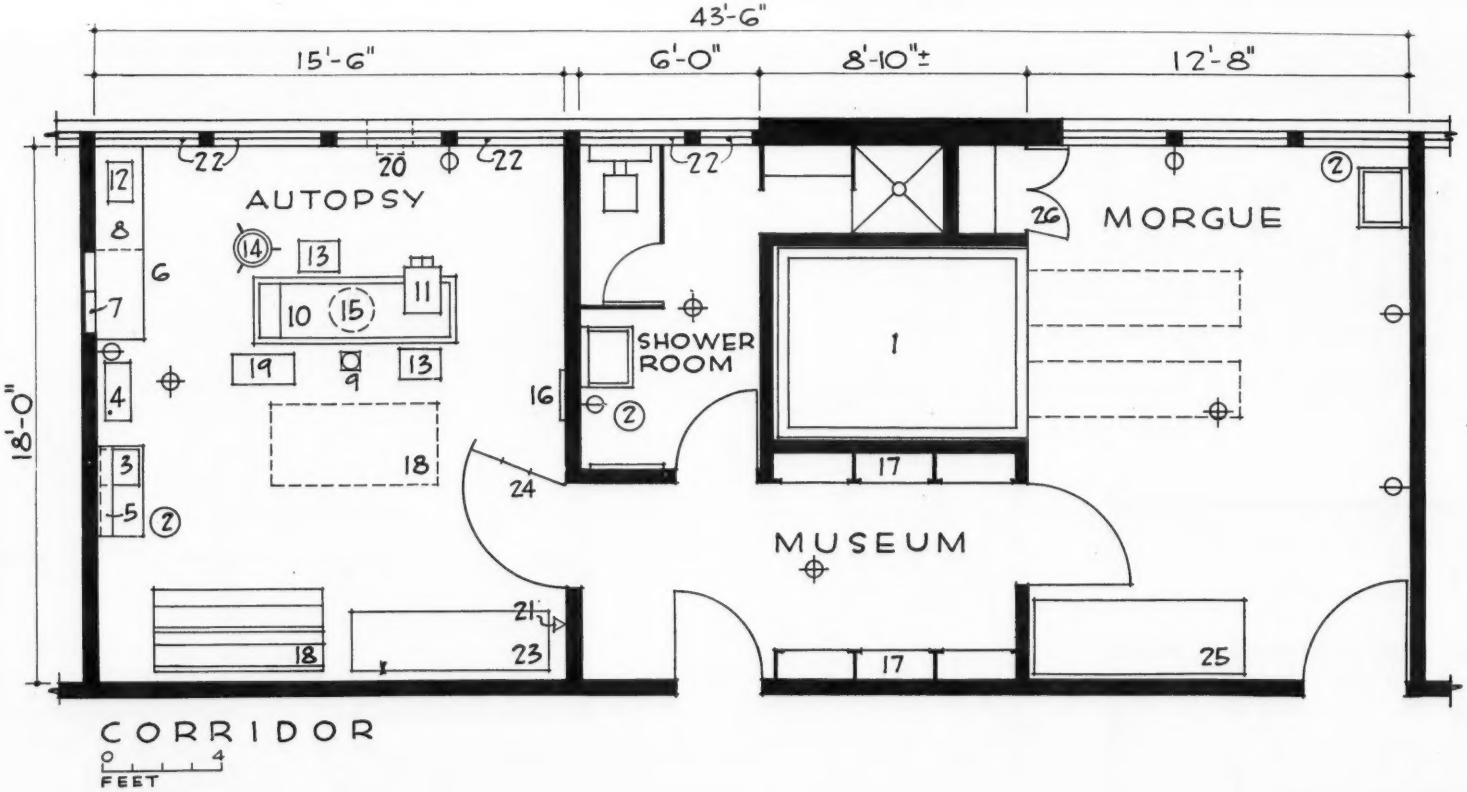
1. Mortuary refrigerator for 2 bodies
2. Waste paper receptacle
3. Combination instrument and scrub sink with gooseneck spout and spray and knee control
4. Instrument sterilizer, 9 x 10 x 20 inches on stand
5. Shelf over sink
6. Cabinet below counter
7. Double recessed view box
8. Counter, 36 inches high, open below
9. Floor drain
10. Autopsy table with sink
11. Mayo table
12. Scales
13. Footstool
14. Kick bucket
15. Light
16. Hook strip
17. Specimen cabinet with glazed doors
18. Metal top table, 16 x 20 inches
19. Suction apparatus
20. Ventilator fan
21. Telephone outlet
22. Obscure glass

7—Morgue and Autopsy Room for a 50-Bed General Hospital



1. Mortuary refrigerator; for 100 bed hospital, 2 bodies; for 200 bed hospital, not less than 3 bodies
2. Waste paper receptacle
3. Combination instrument and scrub sink with gooseneck spout and spray and knee control
4. Instrument sterilizer, 9 x 10 x 20 inches, on stand
5. Shelf over sink
6. Cabinet below counter
7. Double recessed view box
8. Counter, 36 inches high, open below
9. Floor drain
10. Autopsy table with sink
11. Mayo table
12. Scales
13. Footstool
14. Kick bucket
15. Light
16. Hook strip
17. Specimen cabinet with glazed doors
18. Portable observation stand
19. Suction apparatus
20. Ventilating fan
21. Telephone outlet
22. Obscure glass
23. Stretcher
24. View panel

8—Morgue and Autopsy Suite for 100 or 200-Bed General Hospital

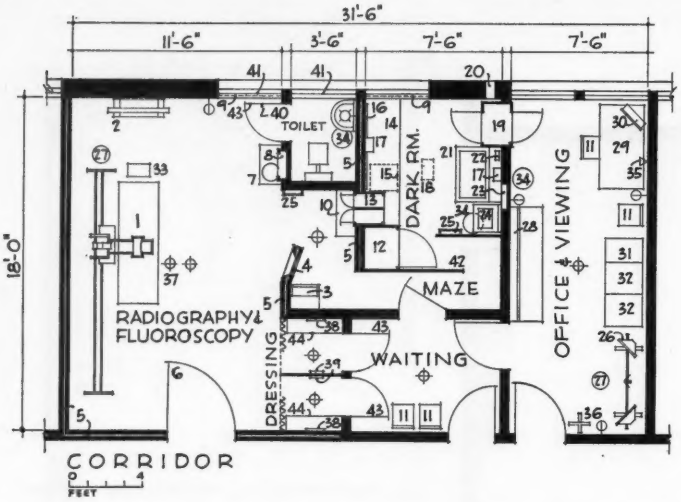


9—Morgue and Autopsy Suite for a 200-Bed General Hospital

1. Mortuary refrigerator for 4 bodies
2. Waste paper receptacle
3. Combination instrument and scrub sink with gooseneck spout and spray and knee control
4. Istrument sterilizer, 9 x 10 x 20 inches, on stand
5. Shelf over sink
6. Cabinet below counter
7. Double recessed view box
8. Counter, 36 inches high, open below
9. Floor drain
10. Autopsy table with sink
11. Mayo table
12. Scales
13. Footstool
14. Kick bucket
15. Light
16. Hook strip
17. Specimen cabinet with glazed doors
18. Portable observation stand
19. Suction apparatus
20. Ventilating fan
21. Telephone outlet
22. Obscure glass
23. Stretcher
24. View panel
25. Table, 30 x 84 inches
26. Closet

(NOTE: This arrangement is recommended for a 200 bed or larger hospital when facilities are to be utilized by a medical examiner.)

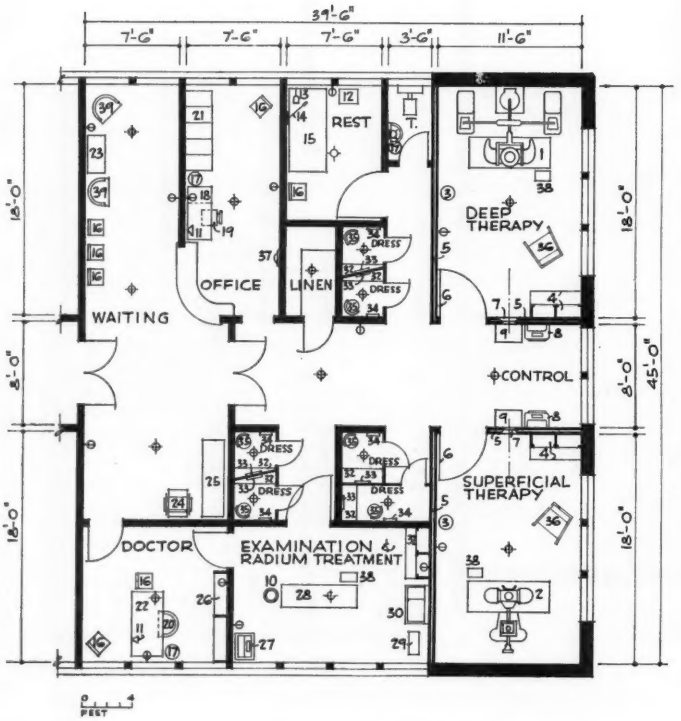
ADJUNCT DIAGNOSTIC AND TREATMENT FACILITIES



10—Radiographic Suite for a 50 or 100-Bed General Hospital

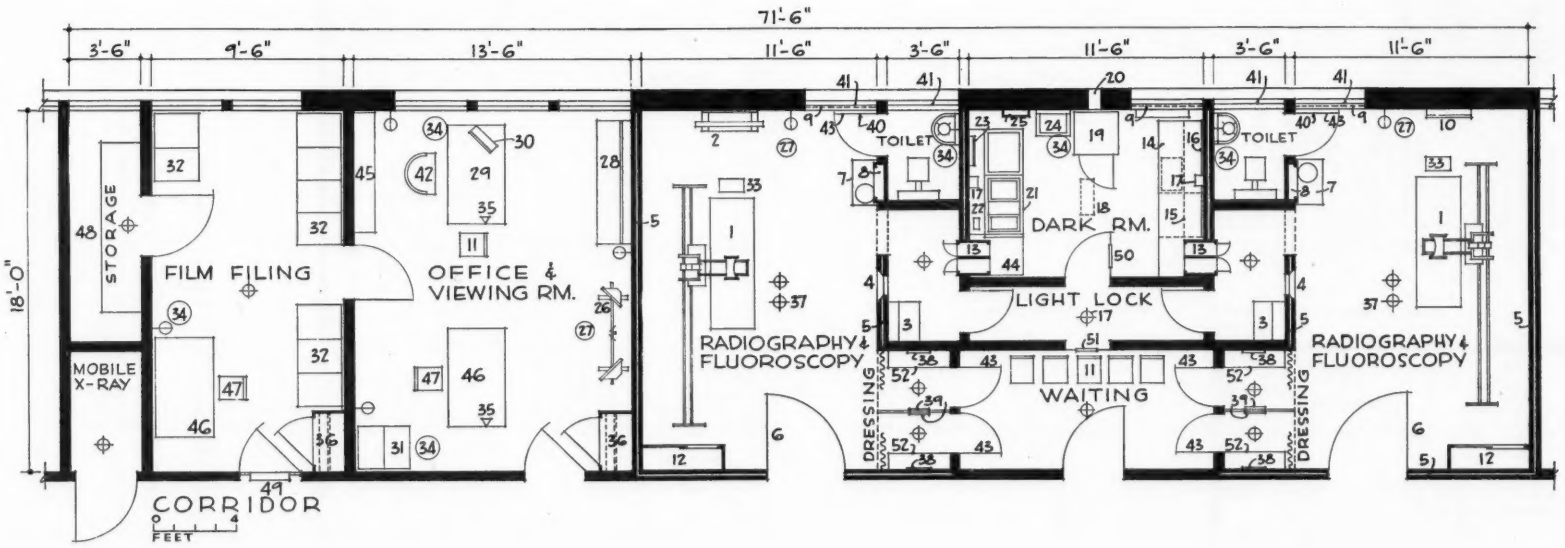
1. Combination radiographic and fluoroscopic unit
2. Cassette changer
3. Control unit
4. Leaded glass view window
5. Lead lining (size and extent varies)
6. Lead-lined door, light proofed
7. Barium sink
8. Recessed cabinet
9. Light-proof shade
10. Low cabinet for supplies
11. Straight chair
12. Storage cabinet
13. Cassette pass box
14. Film loading counter with cabinets below
15. Film storage bin
16. Film hanger racks
17. Safe light
18. Ceiling light, white and red
19. Two-door film dryer
20. Film dryer exhaust
21. Developing tank with thermostatic mixing valve
22. Timer
23. View box, wall mounted
24. Sink
25. Towel bar
26. Stereoscope
27. Adjustable stool
28. Wall-mounted view box, 2 units of 4 each
29. Executive-type desk
30. View box
31. Filing cabinet, letter size, 4 drawers
32. Film filing cabinet, 3 drawers
33. Footstool
34. Waste paper receptacle
35. Telephone outlet
36. Costumer
37. Fluoroscopic ceiling light
38. Hook strip
39. Mirror
40. Hook on door
41. Obscure glass
42. Movable partition
43. Light-proofed door
44. Seat

(NOTE: Maze should be painted dull black. If mobile x-ray unit is to be kept in this area, a storage closet should be provided.)



1. Deep therapy unit
2. Superficial Therapy unit
3. Adjustable stool
4. Supply cabinet
5. Lead Lining (Size and extent varies for floors, walls and ceiling)
6. Lead Lined door
7. Leaded glass view window
8. Control unit
9. Counter, 42 inches high
10. Sanitary waste receptacle
11. Telephone outlet
12. Bedside table
13. Bed light
14. Nurses calling station
15. Bed
16. Straight chair
17. Waste paper receptacle
18. Typewriter desk
19. Typist's chair
20. Desk chair
21. Film filing cabinet
22. Desk
23. Table, 12x26 inches
24. Wheel Chair
25. Wheel stretcher
26. Bookcase
27. Cautery
28. Examining table
29. Instrument sterilizer, 4 x 6 x 16 inches
30. Combination instrument and scrub sink, with gooseneck spout and knee control
31. Instrument cabinet
32. Shelf—31 inches high
33. Mirror
34. Hookstrip
35. Stool with back
36. Non-metallic treatment chair
37. Dome-light and buzzers
38. Foot stool
39. Easy chair

12—X-Ray Therapy Suite for a 200-Bed General Hospital

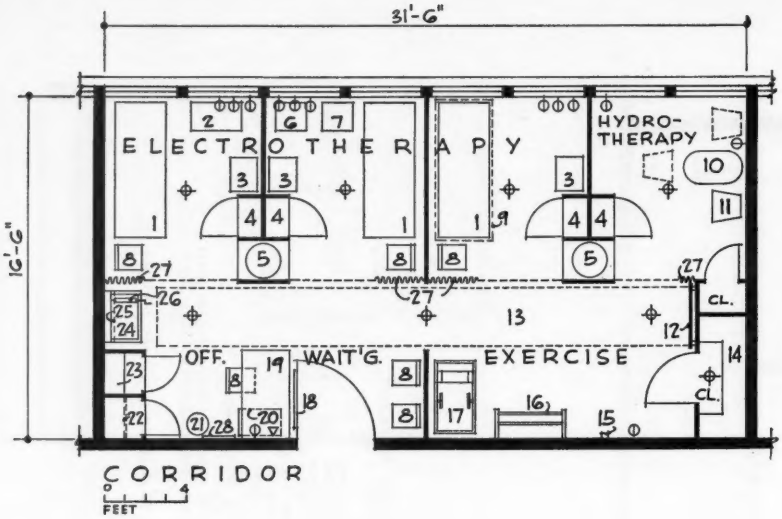


11—*Radiographic Suite for a 200-Bed General Hospital*

1. Combination radiographic and fluoroscopic unit
2. Cassette changer
3. Control unit
4. Leaded glass view window
5. Lead lining (size and extent varies)
6. Lead-lined door, light proofed
7. Barium sink
8. Recessed cabinet
9. Light-proof shade
10. Cassette tunnel
11. Straight chair
12. Storage cabinet
13. Cassette pass box
14. Film loading counter, 36 inches high, with cabinets, cassette bins and film storage bins below
15. Wall cabinet (bottom 3' 8" above counter)
16. Film hanger racks
17. Safe light
18. Ceiling light, white and red
19. Film dryer
20. Film dryer exhaust
21. Developing tank with thermostatic mixing valve
22. Timer
23. View box, wall mounted
24. Sink
25. Towel bar
26. Stereoscope
27. Adjustable stool
28. Wall mounted view box, 2 units of 4 each
29. Executive-type desk
30. View box
31. Filing cabinet, letter size, 4 drawers
32. Film filing cabinet, 3 drawers
33. Footstool
34. Waste paper receptacle
35. Telephone outlet
36. Closet
37. Fluoroscopic ceiling light
38. Hook strip
39. Mirror
40. Hook on door
41. Obscure glass
42. Executive-type chair
43. Light-proofed door
44. Refrigerating unit
45. Book case
46. Typist's desk
47. Typist's chair
48. Shelving, 18 inches wide
49. Dutch door
50. Door with light-proof louvre in upper panel
51. Door with light-proof louvre in lower panel
52. Seat

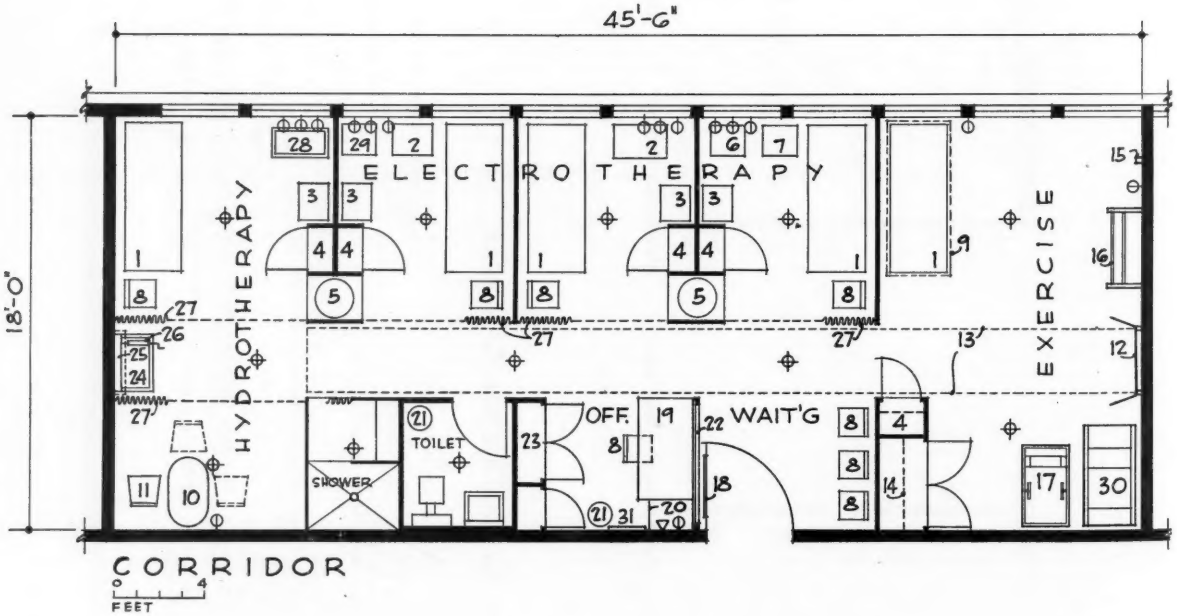
(NOTE: Maze should be painted dull black.)

ADJUNCT. DIAGNOSTIC AND TREATMENT FACILITIES



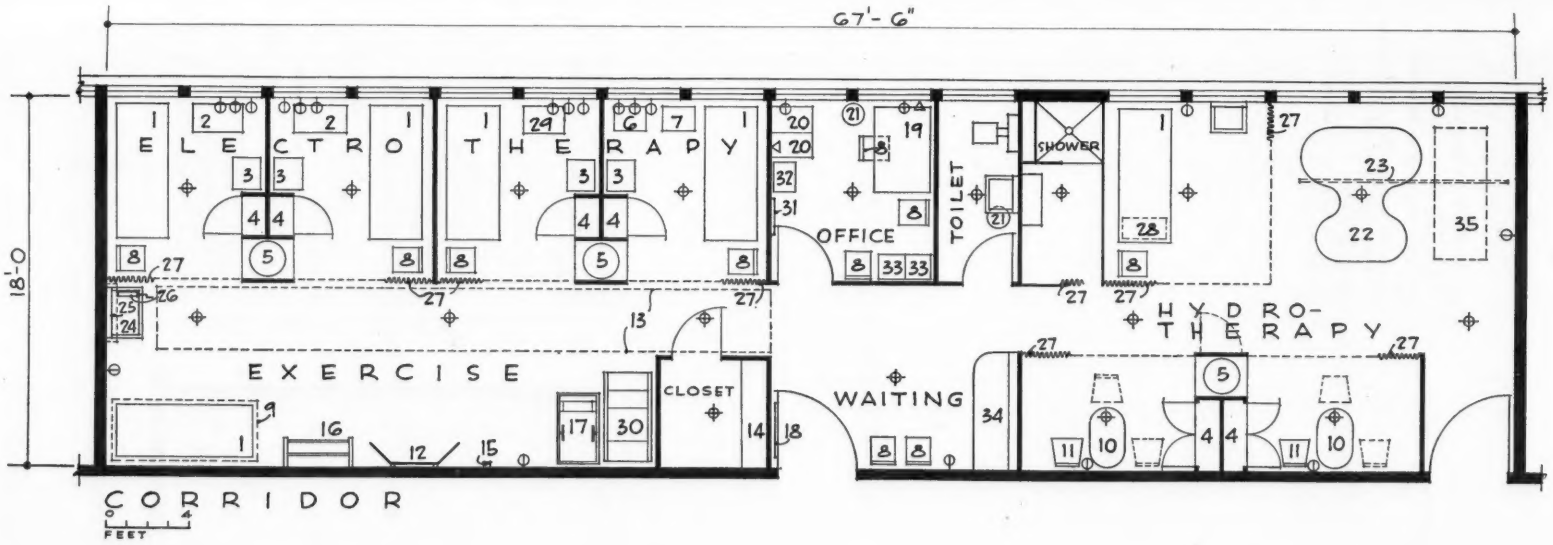
1. Treatment table
2. Short wave unit
3. Table
4. Linen closet
5. Soiled linen hamper, closet over
6. Ultra violet unit
7. Infra red unit
8. Straight chair
9. Ceiling mirror
10. Combination arm and leg whirlpool
11. Adjustable chair for arm or leg treatment
12. Posture mirror
13. Non-skid mat with crutch markings
14. High shelves
15. Shoulder ladder
16. Stall bars
17. Walker
18. Glazed door
19. Desk, 28 by 48 inches
20. Low filing cabinet
21. Waste paper receptacle
22. Hanging rod
23. Adjustable shelves
24. Sink
25. Glass shelf
26. Wringer
27. Curtains and rods
28. Bulletin board, 26 x 24 inches

13—Physical Therapy Suite for a 50-Bed General Hospital



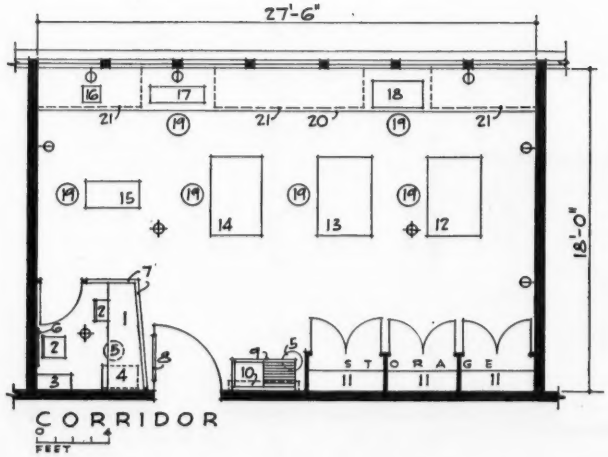
14—Physical Therapy Suite for a 100-Bed General Hospital

1. Treatment table
2. Short wave unit
3. Table
4. Linen closet
5. Soiled linen hamper, closet over
6. Ultra violet unit
7. Infra red unit
8. Straight chair
9. Ceiling mirror
10. Combination arm and leg whirlpool
11. Adjustable chair for arm or leg treatments
12. Posture mirror
13. Non-skid mat with crutch markings
14. High shelves
15. Shoulder ladder
16. Stall bars
17. Walker
18. Glazed door
19. Desk, 28 by 54 inches
20. Filing cabinet
21. Waste paper receptacle
22. Glazed panel
23. Adjustable shelves
24. Sink
25. Glass shelf
26. Wringer
27. Curtains and rods
28. Paraffin tank
29. Low voltage unit
30. Steps
31. Bulletin board, 26 by 24 inches



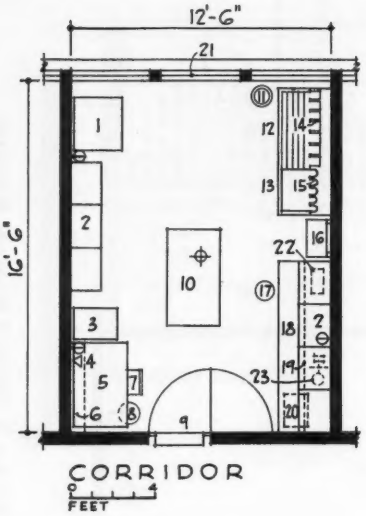
15—Physical Therapy Suite for a 200-Bed General Hospital

1. Treatment table
2. Short wave unit
3. Table
4. Linen closet
5. Soiled linen hamper, closet over
6. Ultra violet unit
7. Infra red unit
8. Straight chair
9. Ceiling mirror
10. Combination arm and leg whirlpool
11. Adjustable chair for arm or leg treatment
12. Posture mirror
13. Non-skid mat with crutch markings
14. High shelves
15. Shoulder ladder
16. Stall bars
17. Walker
18. Glazed door
19. Desk, 32 by 48 inches
20. Filing cabinet
21. Waste paper receptacle
22. Hubbard tank
23. Mono-rail over
24. Sink
25. Glass shelf
26. Wringer
27. Curtains and rods
28. Paraffin tank, built into treatment table
29. Low voltage unit
30. Steps
31. Bulletin board, 26 x 24 inches
32. Typewriter table
33. Locker, 15 by 15 inches
34. Built-in bench
35. Wheel stretcher



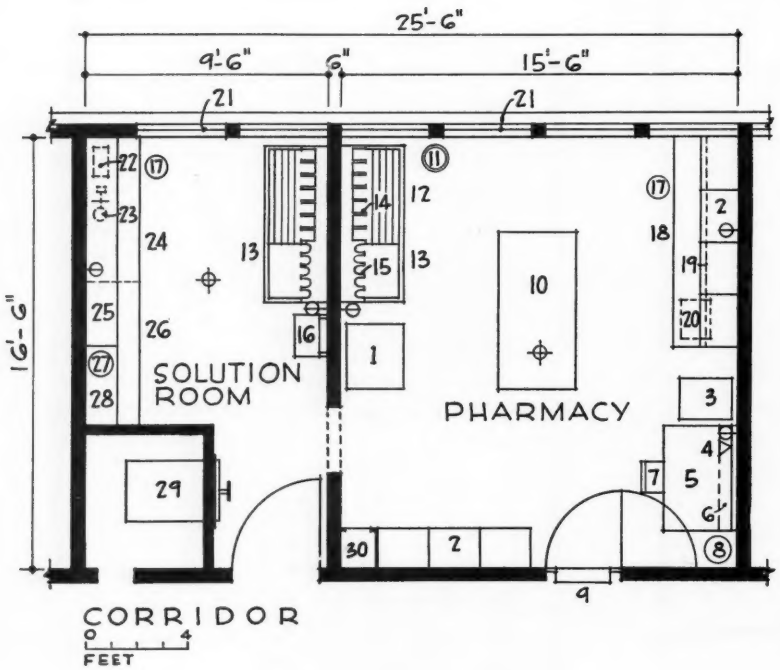
1. Desk
2. Chair
3. Bookcase
4. Filing cabinet
5. Waste paper receptacle
6. Bulletin board, 26 x 24 inches
7. Glazed partitions
8. Glazed panel
9. Non-staining sink and drainboard
10. Shelf over
11. Adjustable shelves
12. Leather work bench
13. Metal work bench
14. Carpentry work bench
15. Bicycle jig saw
16. Electric grinder
17. Electric lathe
18. Table loom
19. Steel
20. Counter, 30 inches high
21. Storage under counter

15A—Occupational Therapy Suite for a 200-Bed General Hospital



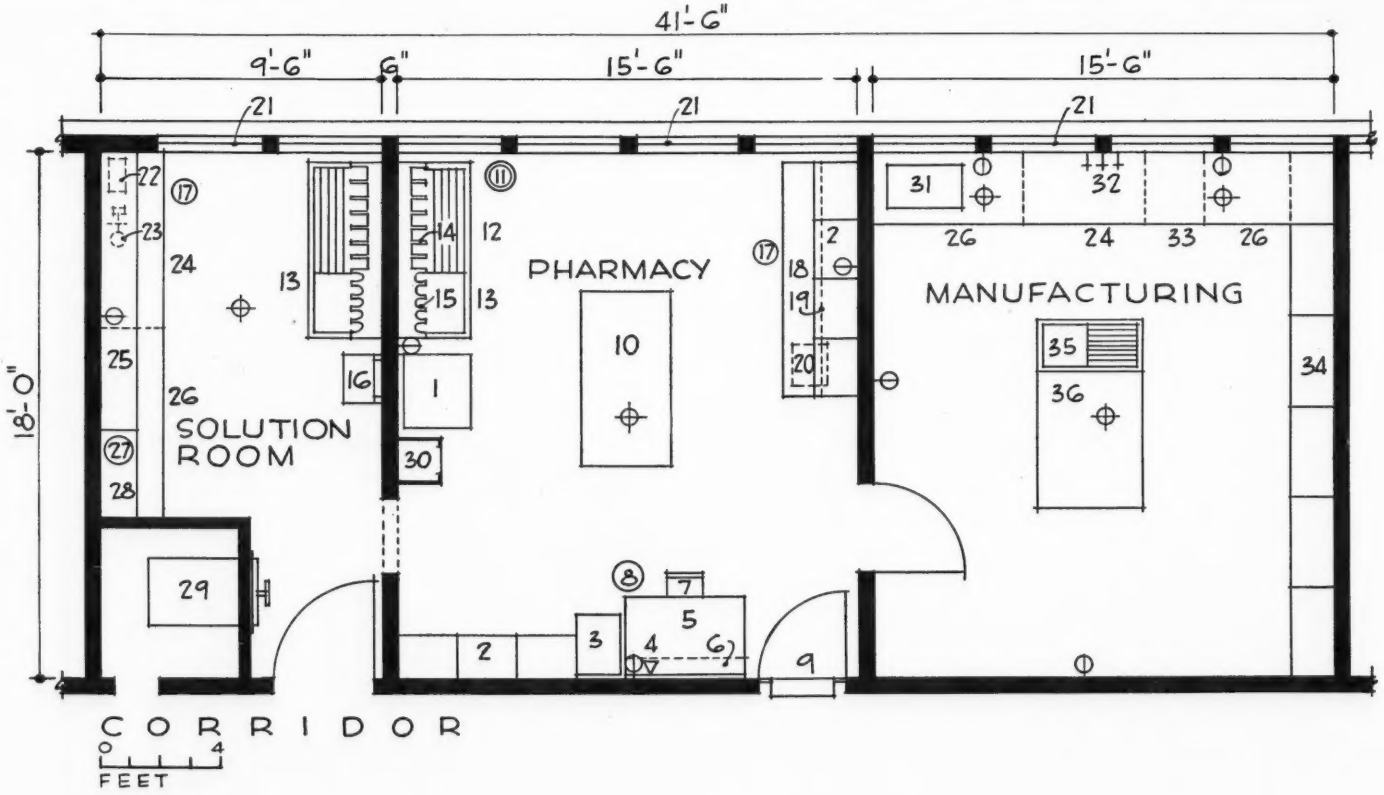
1. Refrigerator, 8 cubic feet
2. Drug cabinet
3. Filing cabinet, letter size, 4 drawers
4. Telephone outlet
5. Desk
6. Book shelves
7. Straight chair
8. Waste paper receptacle
9. Dutch door
10. Table, 30 x 54 inches
11. Sanitary waste receptacle
12. Cabinet below drainboard
13. Acid proof sink and drainboard
14. Drawing pegs
15. Graduate rack
16. Double element hot plate on bracket
17. Stool
18. Prescription counter with cabinets below
19. Fluorescent light below cabinet
20. Narcotics safe
21. Window guards
22. Prescription balance with weights
23. Counter scale with weights

16—Pharmacy for a 50-Bed General Hospital



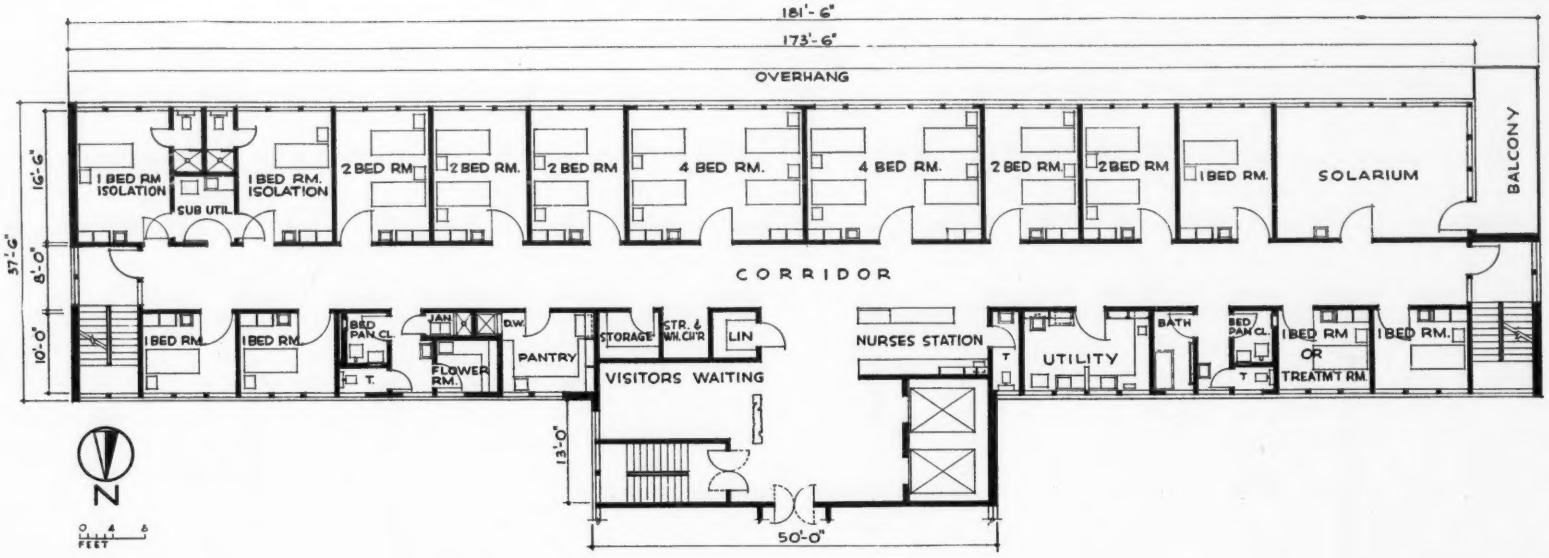
1. Refrigerator, 8 cubic feet
2. Drug cabinet
3. Filing cabinet, letter size, 4 drawers
4. Telephone outlet
5. Desk
6. Book shelves
7. Straight chair
8. Waste paper receptacle
9. Dutch door
10. Table, 30 x 54 inches
11. Sanitary waste receptacle
12. Cabinet below drainboard
13. Acid proof sink and drainboard
14. Drawing pegs
15. Graduate rack
16. Double element hot plate on bracket
17. Stool
18. Prescription counter with cabinets below
19. Fluorescent light below cabinet
20. Narcotics safe
21. Window guards
22. Prescription balance with weights
23. Counter scale
24. Counter, 36 inches wide with water resistant top
25. Shelf, 18 inches above counter
26. Cabinets below counter
27. Water still, 5 gal. per hr.
28. Shelf, 36 inches above counter
29. Rectangular sterilizer, 24 x 24 x 36 inches, nickel clad
30. Locker

17—Pharmacy for a 100-Bed General Hospital



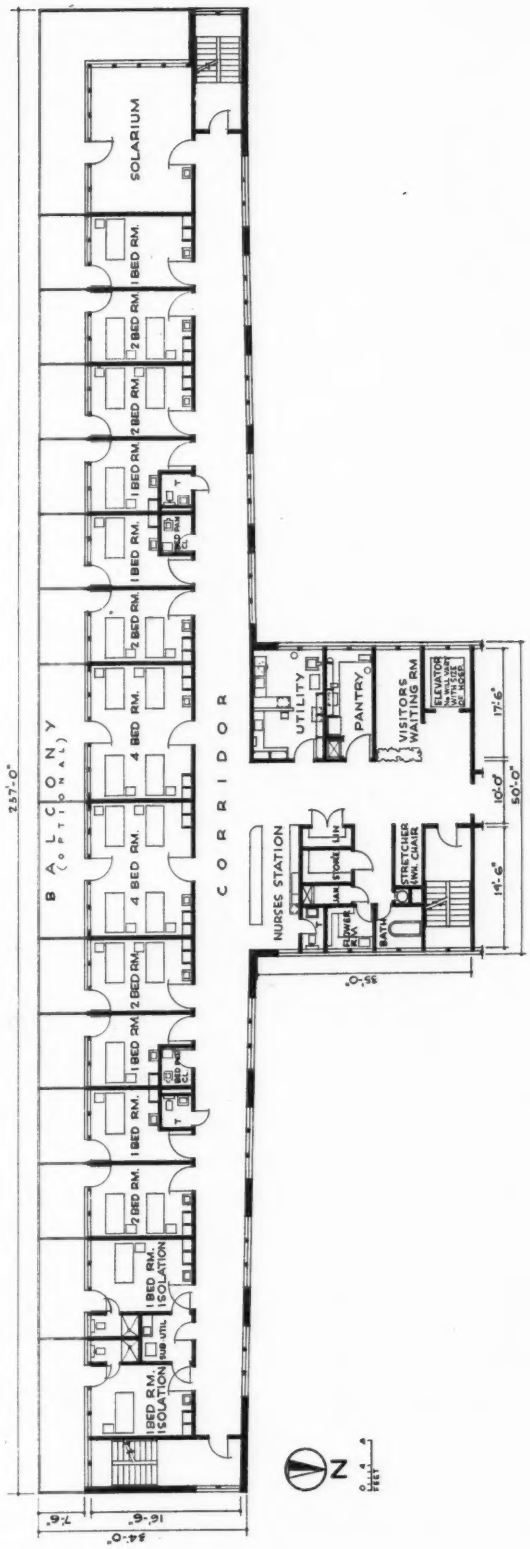
18—*Pharmacy for a 200-Bed General Hospital*

1. Refrigerator, 8 cubic feet
2. Drug cabinet
3. Filing cabinet, letter size, 4 drawers
4. Telephone outlet
5. Desk
6. Book shelves
7. Straight chair
8. Waste paper receptacle
9. Dutch door
10. Table, 30 x 54 inches
11. Sanitary waste receptacle
12. Cabinet below drainboard
13. Acid proof sink and drainboard
14. Drawing pegs
15. Graduate rack
16. Double element hot plate on bracket
17. Stool
18. Prescription counter with cabinets below
19. Fluorescent light below cabinet
20. Narcotics safe
21. Window guards
22. Prescription balance with weights
23. Counter scale
24. Counter, 36 inches wide with water resistant top
25. Shelf, 18 inches above counter
26. Cabinets below counter
27. Water still, 5 gal. per hr.
28. Shelf, 36 inches above counter
29. Rectangular sterilizer, 24 x 24 x 36 inches, nickel clad
30. Locker
31. Opaque glass insert in counter
32. Gas, compressed air and vacuum outlets
33. Drawers below counter
34. Adjustable metal shelves above counter height, cabinets below
35. Sink and drainboard
36. Table with soap stone top



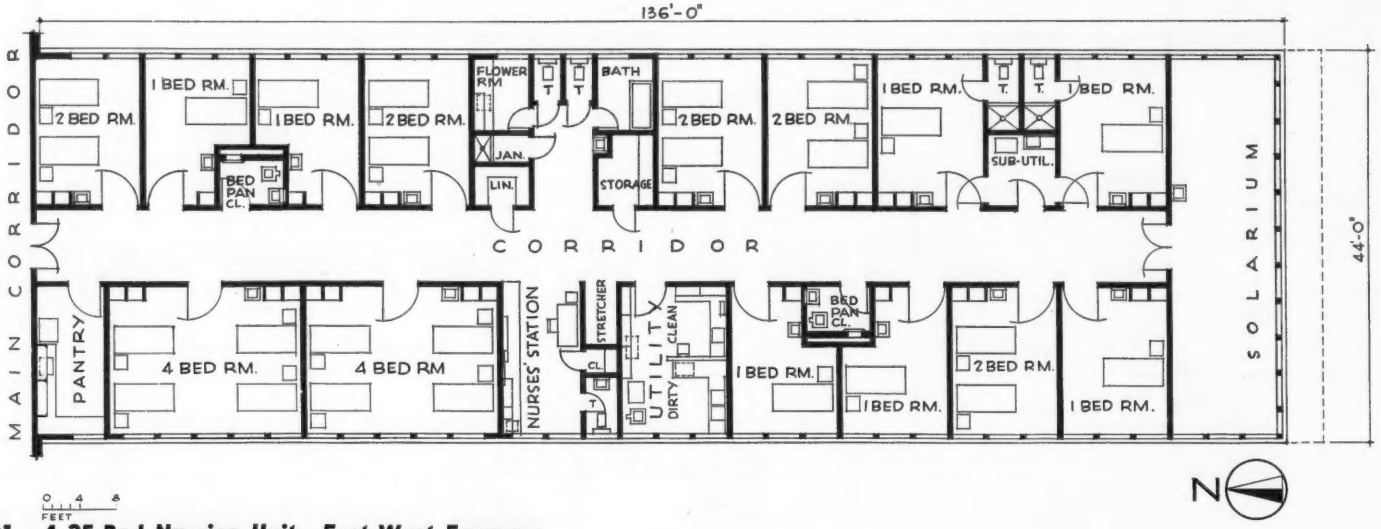
19—*A 25-Bed Nursing Unit—Southern Exposure with Offset Corridor*

***ORIENTATION NOTE**—Building should be oriented so that nursing units receive benefit of southern exposure, prevailing winds and maximum quiet.*

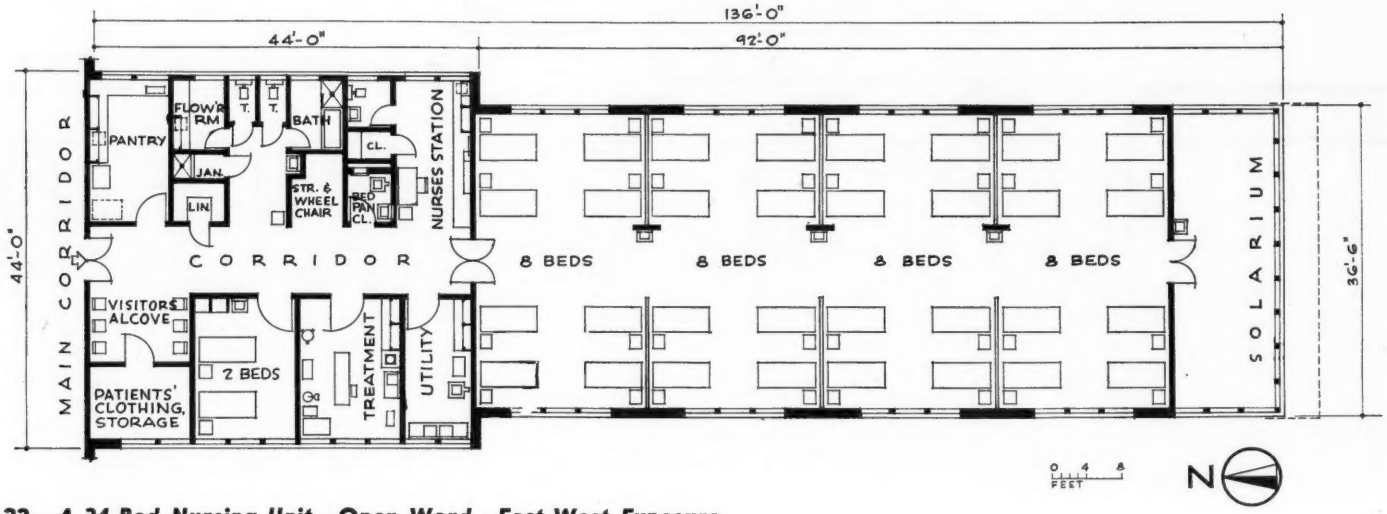


20—A 25-Bed Nursing Unit—Southern Exposure

ORIENTATION NOTE—*Building should be oriented so that nursing units receive benefit of southern exposure, prevailing winds and maximum quiet.*

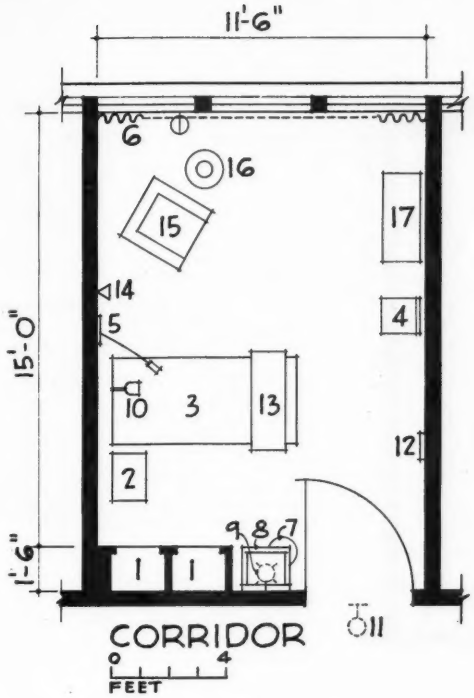


21—*A 25-Bed Nursing Unit—East-West Exposure*



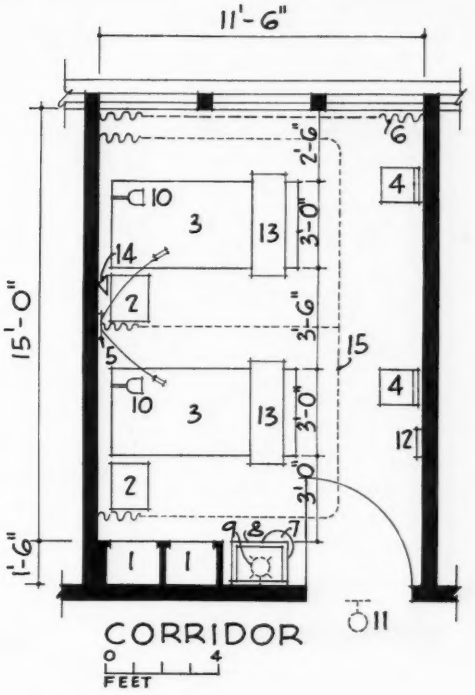
22—*A 34-Bed Nursing Unit—Open Ward—East-West Exposure*

ORIENTATION NOTE—Building should be oriented so that nursing units receive benefit of southern exposure, prevailing winds and maximum quiet.



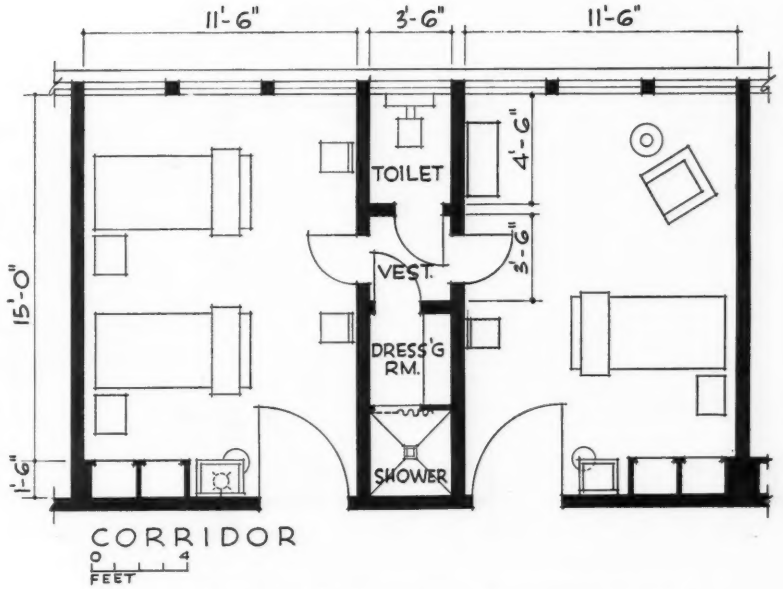
23—*Typical One-Bed Room*

1. Built-in locker
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Telephone outlet
15. Easy chair
16. Floor lamp
17. Dresser



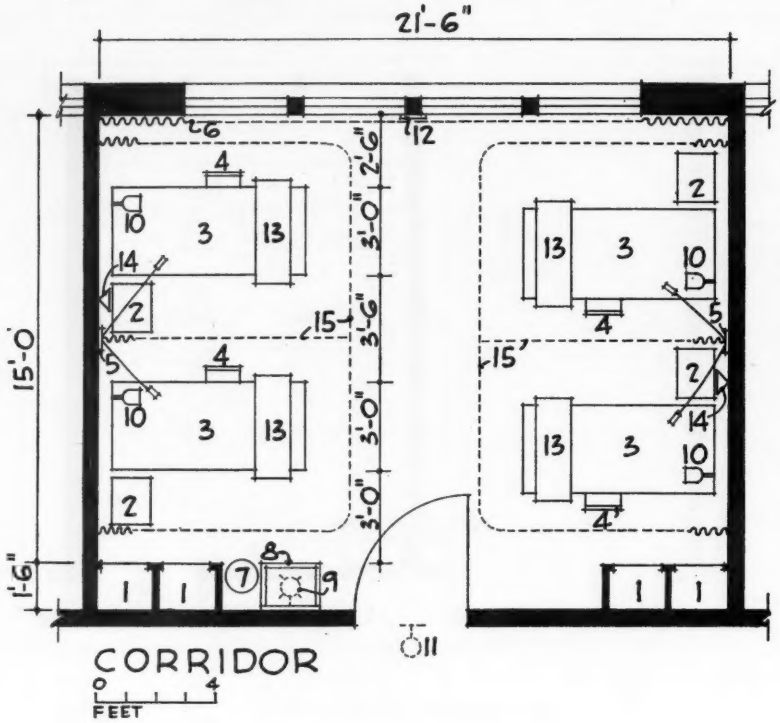
24—*Typical Two-Bed Room*

1. Built-in locker
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Telephone outlet
15. Cubicle rod and curtain



25—*Bed Rooms with Connecting Shower and Toilet*

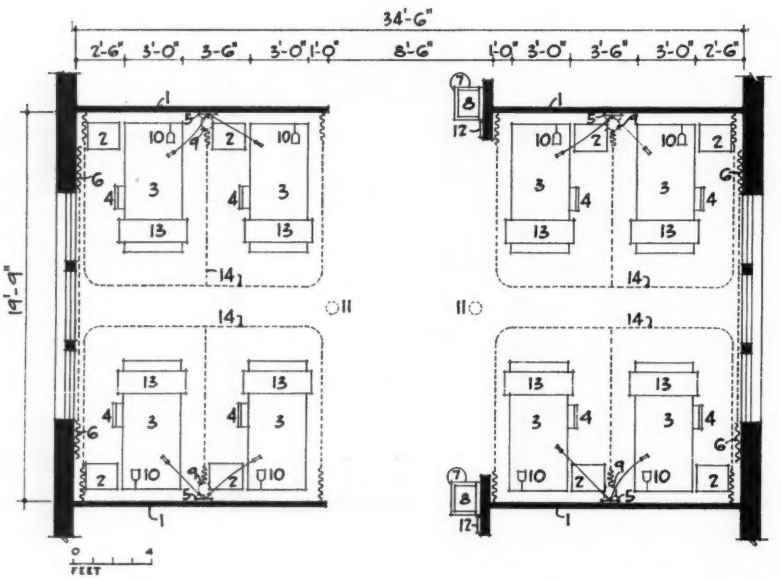
NURSING DEPARTMENT



1. Built-in locker
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Telephone outlet
15. Curtain rod and curtain

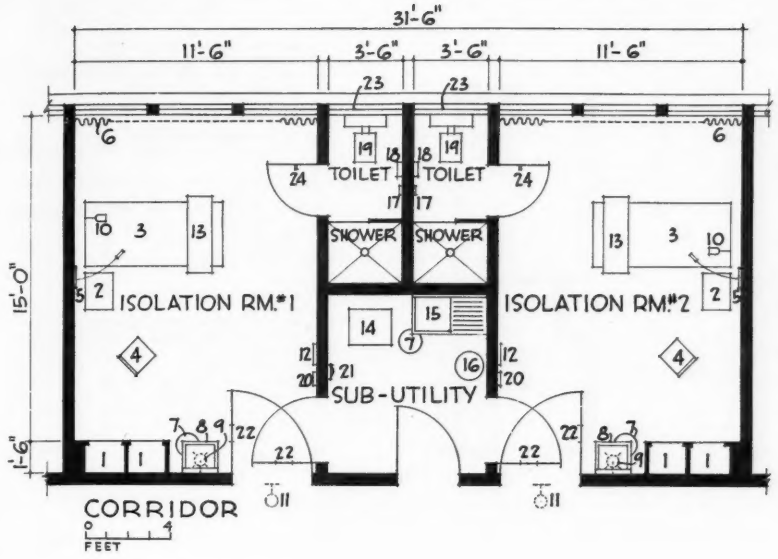
(NOTE: The length of this room should be 24 feet if it is desired that the room be divided into two two-bed rooms at some later date.)

26—Typical Four-Bed Room



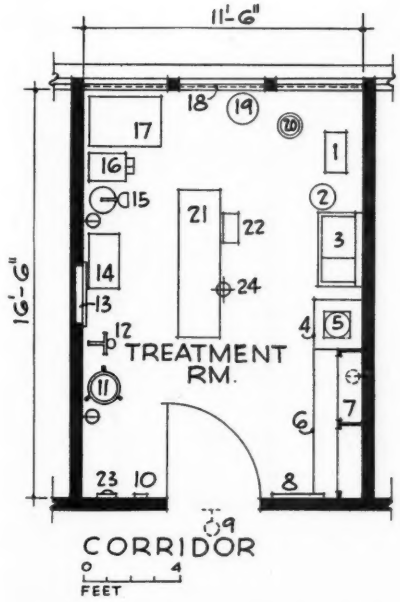
1. Partition, 7 feet 6 inches high
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Indirect fixture at top of partition, switch controlled
10. Bed light
11. Ceiling dome light
12. Night light, switch controlled
13. Overbed table
14. Cubicle curtain and rod

27—Typical Open Ward



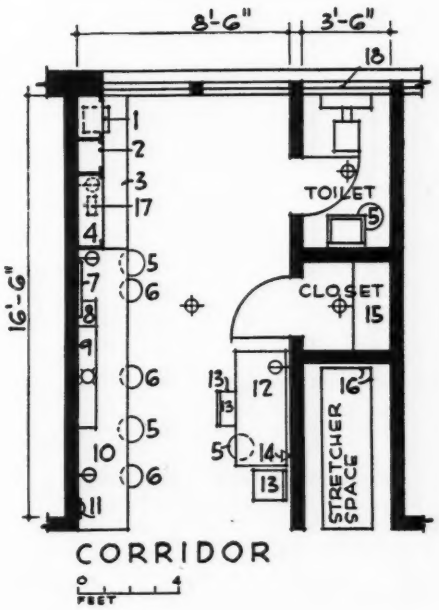
28—*Isolation Suite*

1. Built-in locker
2. Bedside cabinet
3. Adjustable hospital bed
4. Straight chair
5. Nurses' calling station with duplex receptacle, contagious type
6. Sliding window curtain
7. Waste paper receptacle
8. Lavatory with gooseneck spout and knee or elbow control
9. Wall bracket light, switch controlled
10. Bed light
11. Corridor dome light
12. Night light, switch controlled
13. Overbed table
14. Utensil sterilizer, 20 x 20 x 24 inches
15. Sink and drainboard
16. Linen hamper
17. Nurses' calling station (push button type)
18. Grab rail
19. Water closet with bed pan lugs and bed pan flushing attachment
20. Hook strip
21. Dome light and buzzer, 5 feet 6 inches above floor
22. View panel
23. Obscure glass
24. Coat hook



29—*Treatment Room for Nursing Floor*

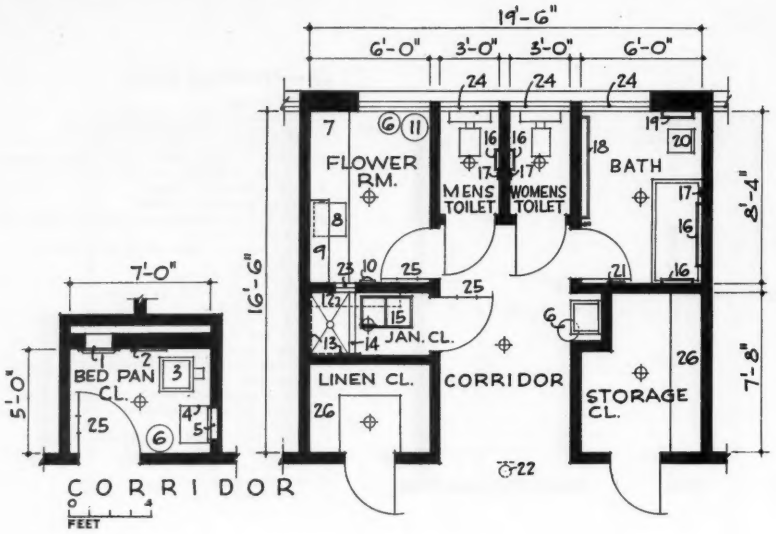
1. Instrument sterilizer, 9 x 10 x 20 inches
2. Waste paper receptacle
3. Combination instrument and scrub sink with gooseneck spout and spray and knee control
4. Counter, 29 inches high, open below
5. Single element hot plate
6. Counter, 36 inches high, with cabinets below
7. Wall cabinet
8. Bulletin board, 26 x 24 inches
9. Corridor domelight
10. Nurses' call (connected to nurses' station)
11. Kick bucket
12. Irrigator stand
13. Double recessed view box
14. Dressing cart
15. Examining light
16. Mayo table
17. Instrument table, 24 x 36 inches
18. Light proof shades
19. Adjustable stool
20. Sanitary waste receptacle
21. Examining table
22. Footstool
23. Domelight and buzzer set 5 feet 6 inches from floor
24. Ceiling fixture



30—*Nurses' Station and Stretcher Space*

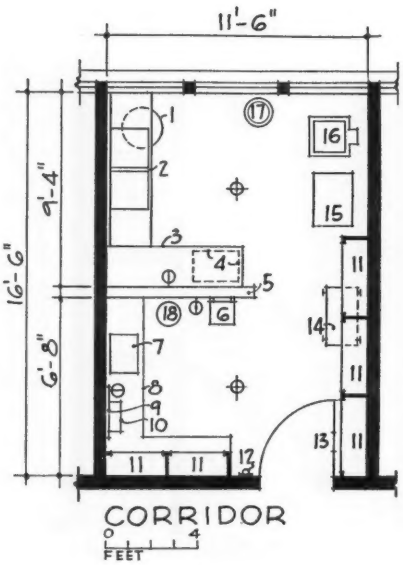
1. Medicine sink in counter with gooseneck spout
2. Locked wall cabinet with inner locked narcotic compartment and inside light
3. Counter, 36 inches high, with cabinets below
4. Wall cabinet
5. Waste paper receptacle
6. Stool
7. Bulletin board, 26 x 24 inches
8. Pigeonhole form rack
9. Chart rack
10. Counter, 30 inches high, open below
11. Domelight and buzzer set, 5 feet 6 inches from floor
12. Nurses' desk
13. Straight chair
14. Telephone outlet
15. Shelving
16. Wheel stretcher
17. Instrument sterilizer, 3 x 3⅜ x 8½ inches
18. Obscure glass

NURSING DEPARTMENT

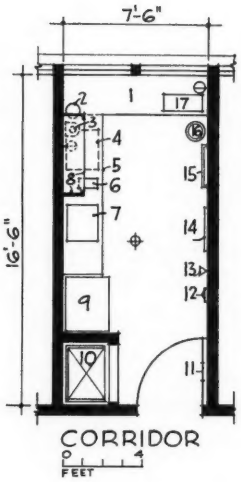


1. Bed pan washer and sterilizer
2. Bulletin board, 26 x 24 inches
3. Clinical sink with bed pan flushing attachment
4. Table, 16 x 20 inches
5. Recessed cabinet
6. Waste paper receptacle
7. Counter, 36 inches high, with open shelving below
8. Sink in counter
9. Two shelves
10. Domelight and buzzer set, 5 feet 6 inches from floor
11. Galvanized iron can
12. Shelf
13. Hook strip for grip sticks
14. Curb
15. Mop truck
16. Grab rail
17. Nurses' calling station (push button type)
18. Drying rod set, 5 feet 6 inches from floor
19. Towel bar
20. Straight chair
21. Hook strip
22. Corridor dome light
23. Ventilating grille
24. Obscure glass
25. Vision panel
26. Shelving

31—Service Group for Nursing Unit



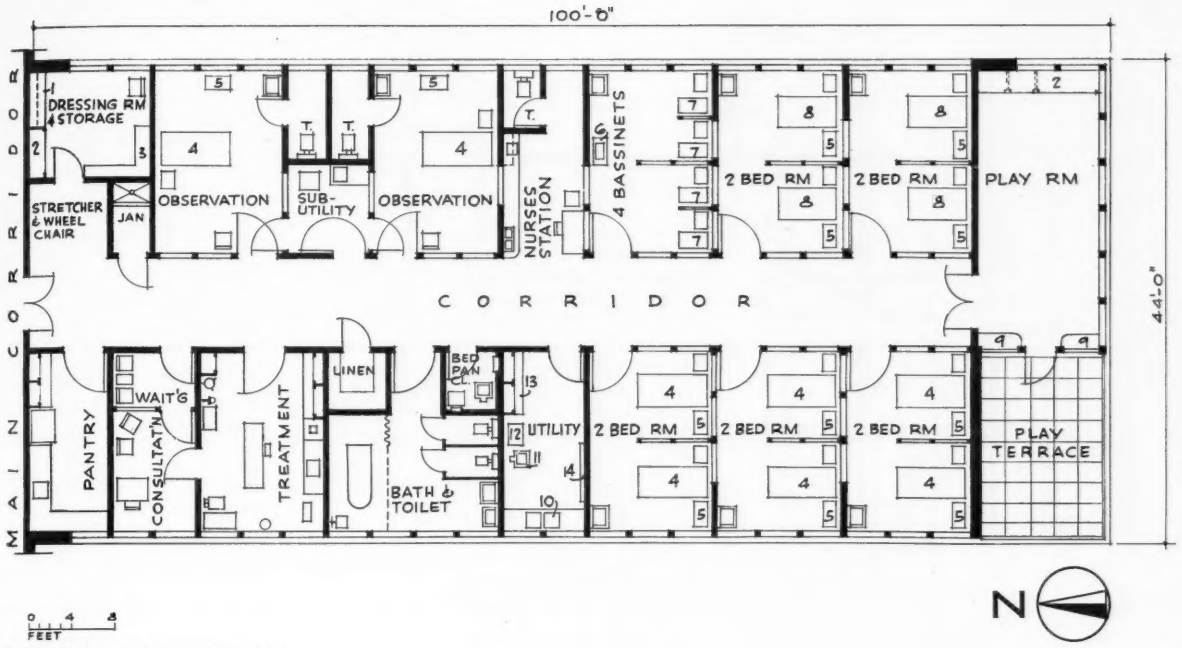
32—Utility Room



33—Floor Pantry (for Central Tray Service)

1. Laundry hamper
2. Double compartment laundry tray with drainboards
3. Counter, 36 inches high, open below
4. Cracked ice bin (for external use only)
5. Partition, 4 feet 6 inches high
6. Single element hot plate on bracket
7. Sink in counter with gooseneck spout and knee or elbow control
8. Counter, 36 inches high, with cabinets below
9. Bulletin board, 26 x 24 inches
10. Instrument sterilizer, 4 x 6 x 16 inches
11. Wall cabinet
12. Domelight and buzzer set, 5 feet 6 inches from floor
13. Vision panel
14. Dressing cart
15. Utensil sterilizer, 20 x 20 x 24 inches
16. Clinical sink
17. Sanitary waste receptacle
18. Waste paper receptacle

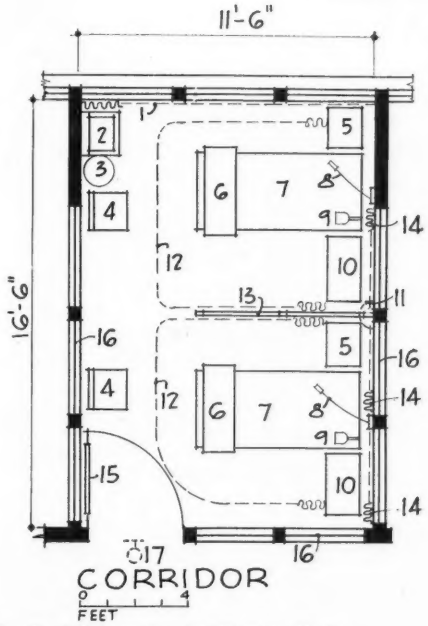
1. Counter, 36 inches high, open below
2. Juice extractor
3. Beverage mixer
4. Cracked ice bin
5. Counter, 36 inches high, with cabinets below
6. Electric toaster
7. Sink in counter
8. Wall cabinet
9. Refrigerator, 8 cubic feet
10. Dumbwaiter (32 x 20 inches cab) connected with kitchen
11. Vision panel
12. Domelight and buzzer set, 5 feet 6 inches from floor
13. Telephone connection to kitchen
14. Bulletin board, 26 x 24 inches
15. Towel bar
16. Sanitary waste receptacle
17. Double element hot plate



34—Pediatric Nursing Unit

1. Clothes pole with shelf over
2. Storage cabinet
3. Shelving
4. Adjustable hospital bed
5. Toy and clothes cabinet
6. Infant scale
7. Bassinet
8. Crib
9. Toy shelves
10. Double compartment laundry tray and drainboards
11. Clinical sink
12. Utensil sterilizer, 20 x 20 x 24 inches
13. Counter, 36 inches high, with cabinets and cracked ice bin below; wall cabinets above
14. Drying rod

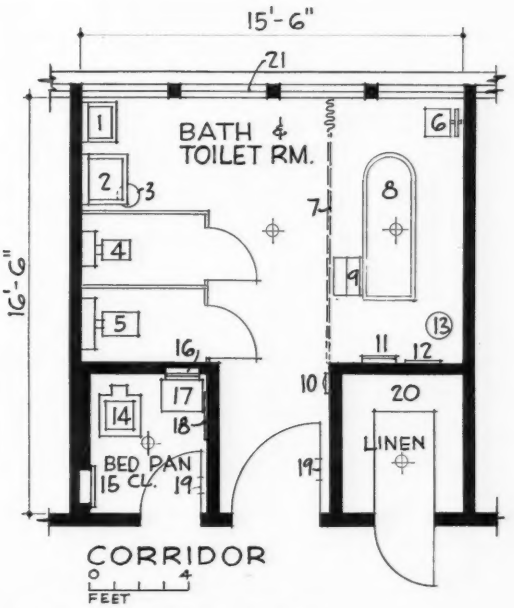
(NOTE: Five patient rooms may be added to this unit with no additional service rooms.)



35—Bed Room for Pediatric Unit

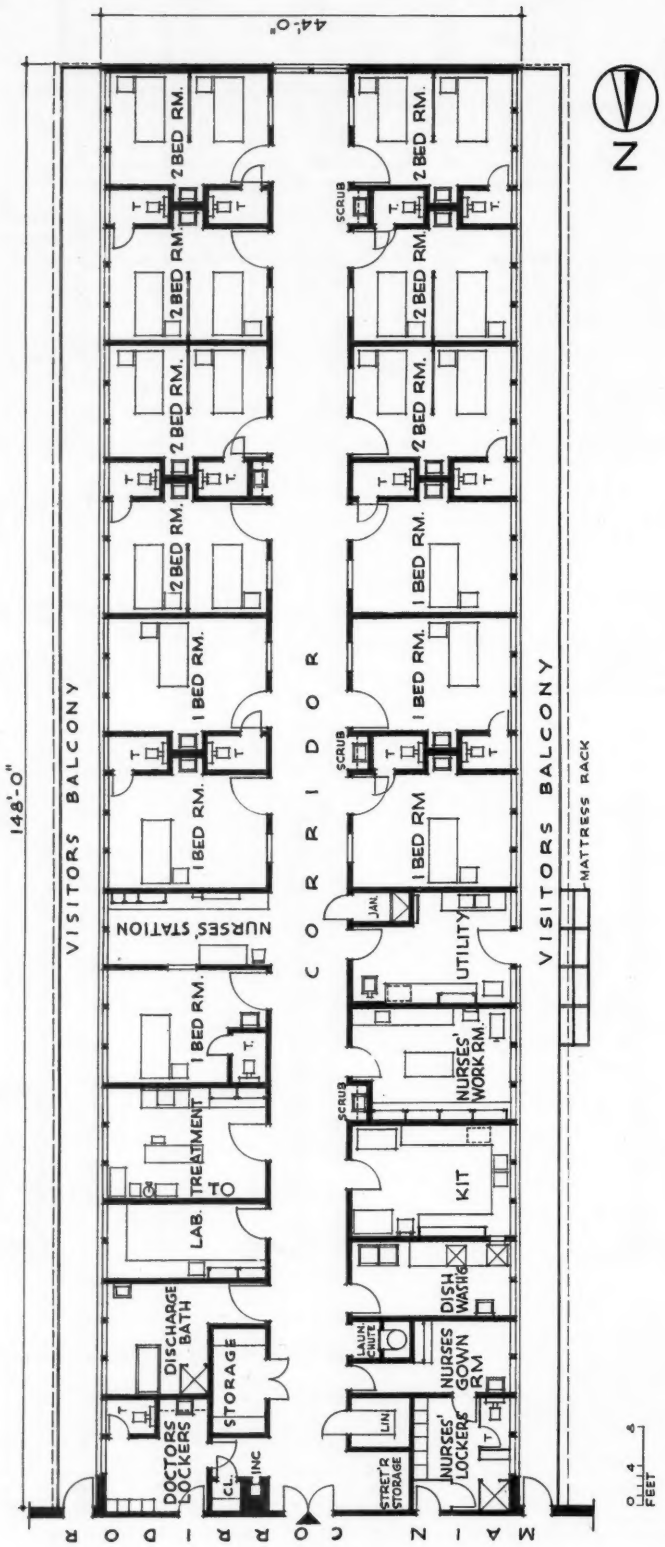
1. Sliding window curtain
2. Lavatory with gooseneck spout and knee or elbow control
3. Waste paper receptacle
4. Straight chair
5. Bedside cabinet
6. Overbed table
7. Adjustable hospital bed*
8. Nurses' calling station with duplex receptacle
9. Bed light
10. Toy and clothes cabinet
11. Indirect wall fixture above top of cubicle partition
12. Cubicle curtain and curtain rod.
13. Cubicle partition, 7 feet high with bottom of clear glass set 36 inches above floor
14. Curtain
15. Door with clear glass in upper panel
16. Clear glass beginning 36 inches above floor
17. Corridor dome light

**Cribs may be substituted as required.*

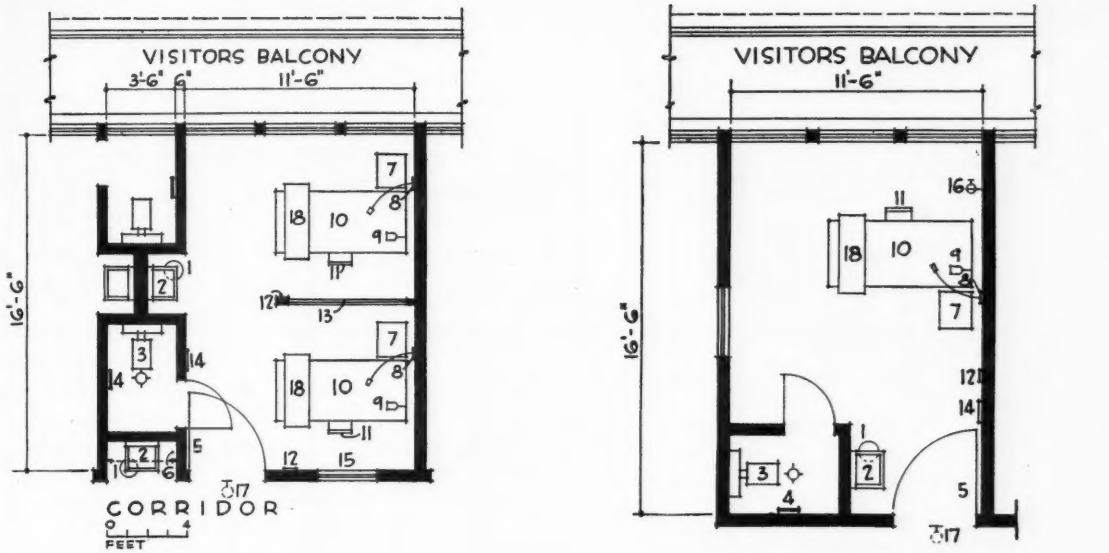


36—Bath Room for Pediatric Unit

1. Lavatory—junior size
2. Lavatory—adult size
3. Waste paper receptacle
4. Water closet—junior size
5. Water closet—adult size
6. Adult scale
7. Curtain and rod
8. Bath tub, pedestal type, with controls on wall
9. Steps
10. Domelight and buzzer set 5 feet 6 inches from floor
11. Towel bar
12. Hook strip
13. Stool
14. Clinical sink with bed pan flushing attachment
15. Bed pan washer and sterilizer
16. Recessed cabinet
17. Table, 16x20 inches
18. Bulletin board, 26x24 inches
19. Vision panel
20. Shelving
21. Obscure glass

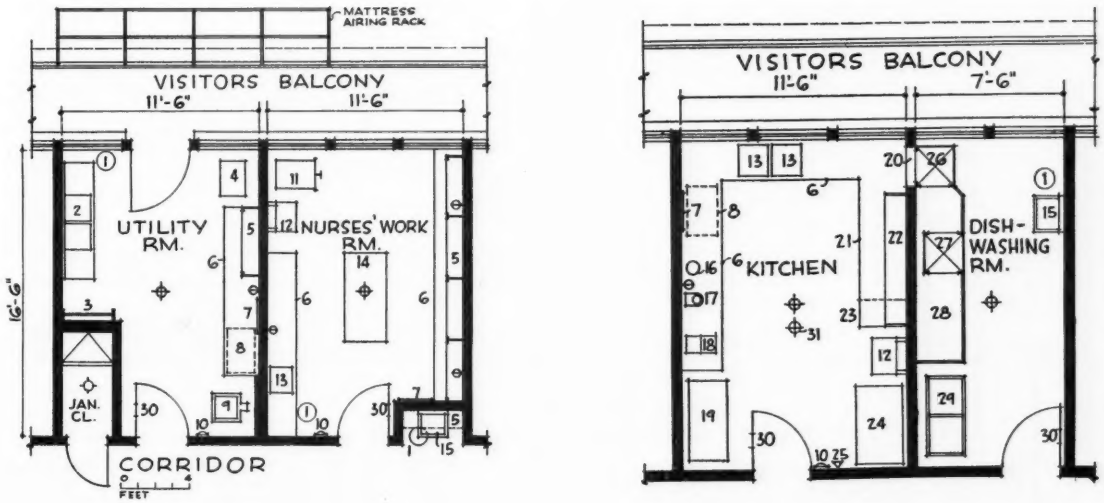


37—Contagious Disease Nursing Unit



38—Bed Rooms for Contagious Disease Nursing Unit

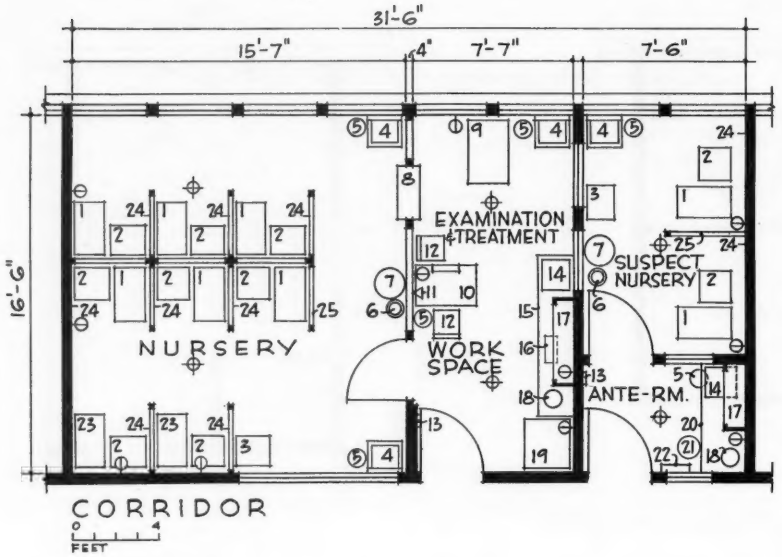
1. Waste paper receptacle
2. Lavatory with gooseneck spout and foot control
3. Water closet with bed pan lugs and bed pan flushing attachment
4. Grab rail
5. Door with clear glass in upper panel
6. Wall cabinet over lavatory
7. Bedside cabinet
8. Nurses' calling station, contagious type with duplex receptacle
9. Bed light
10. Adjustable hospital bed
11. Straight chair
12. Hook strip
13. Cubicle partition, 7 feet high with bottom of clear glass set 36 inches above floor.
14. Night light
15. View window, clear glass
16. Steam outlet (for bed rooms on both sides of and across the corridor from nurses' station)
17. Corridor dome light
18. Over bed table



39—Contagious Disease Utility Room and Nurses Work Room, Kitchen and Dishwashing Room

1. Waste paper receptacle
2. Double compartment laundry tray with drainboards
3. Drying rod, 5 feet, 6 inches, from floor
4. Utensil sterilizer, 20x20x24 inches
5. Wall cabinet
6. Counter, 36 inches high, with cabinets below
7. Bulletin board, 26x24 inches
8. Cracked ice bin (in utility room, for external use only)
9. Clinical sink
10. Domelight and buzzer set, 5 feet, 6 inches from floor
11. Dressing sterilizer, 16x24 inches
12. Double element hot plate on bracket
13. Sink in counter, 14 inches deep
14. Table, 30x60 inches
15. Lavatory with gooseneck spout and foot control
16. Juice extractor
17. Beverage mixer
18. Electric toaster
19. Tray truck
20. Sliding sash
21. Dish warming compartment below counter
22. Open shelves above counter
23. Tray compartment below counter
24. Refrigerator, 20 cubic feet
25. Telephone outlet
26. Dish washing machine with heater
27. Dish washing machine
28. Solid dish counter
29. Double compartment sink 14 inches deep
30. Vision panel
31. Overhead plug for food cart

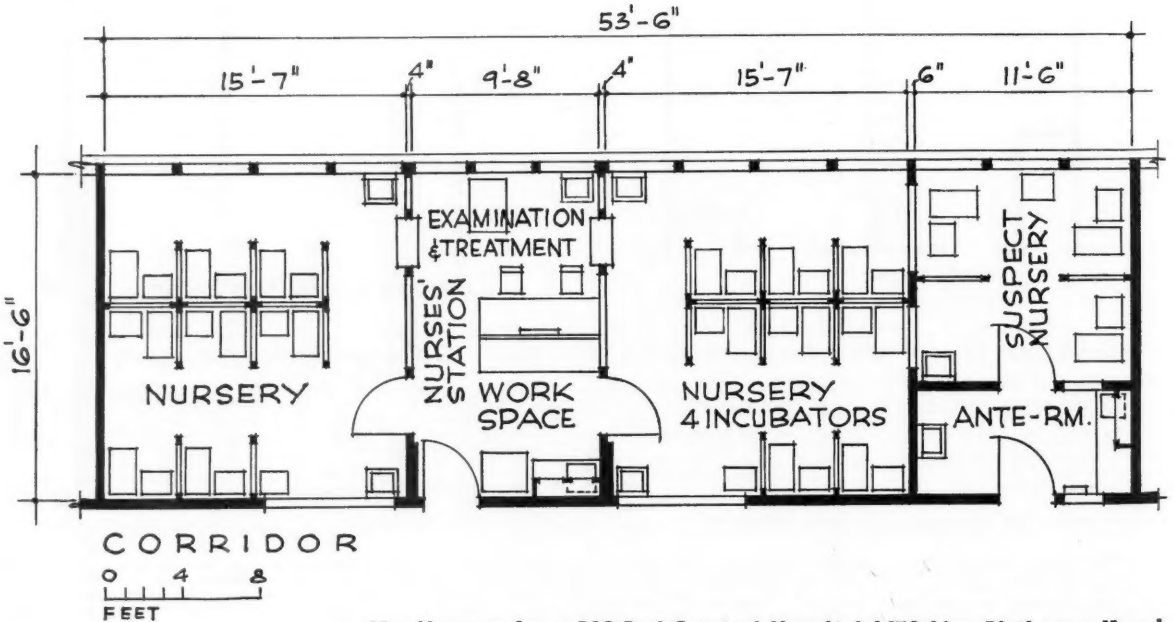
(NOTE: Heat is the most important factor in the destruction of bacteria during the dishwashing process. A temperature of at least 170 degrees F. is required for effective bactericidal action. The domestic water supply cannot always be depended upon to provide water of required temperature. Therefore the above arrangement has been devised whereby one machine (No. 27) is used for washing dishes at 140 degrees F., using the domestic supply. The other machine (No. 26), with a thermostatically controlled heater to insure a water temperature of 170 degrees F., is used for final rinsing. With this arrangement dishes can be rinsed for longer periods without diluting or overheating the wash water as would be the case if one single tank machine was used. The washing compartments should be large enough to admit a rack of trays.)



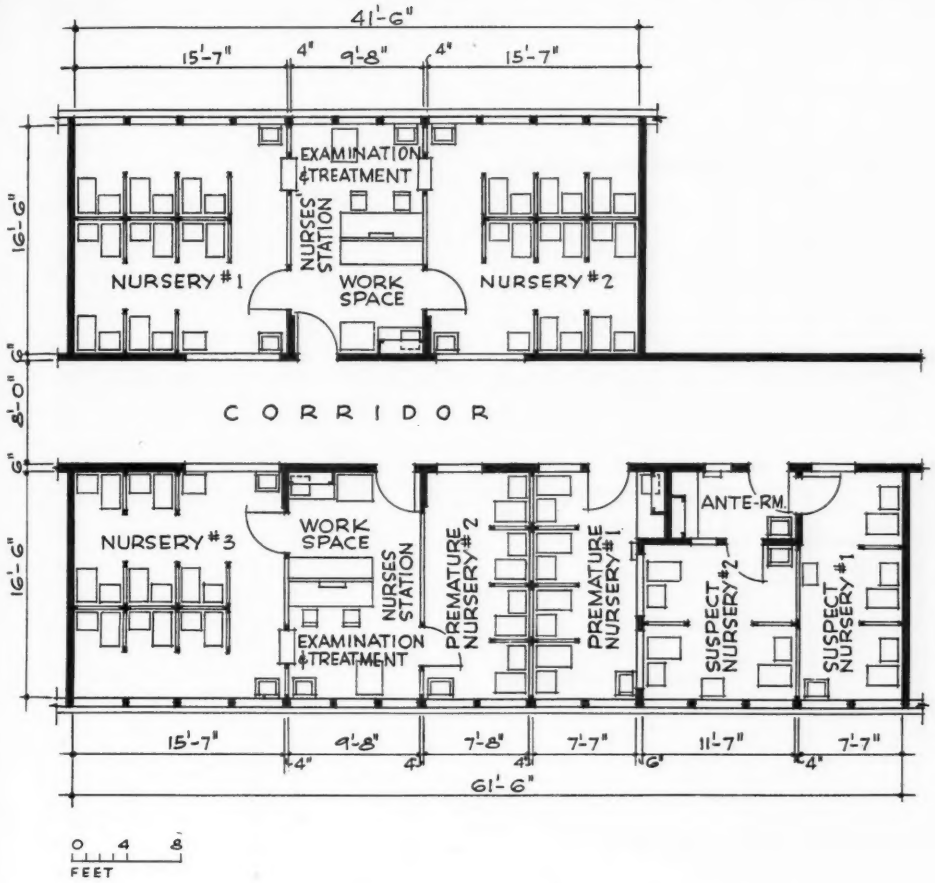
1. Bassinet
2. Bedside cabinet
3. Table, 16x24 inches (for infant scale)
4. Lavatory with gooseneck spout and knee control
5. Waste paper receptacle
6. Sanitary waste receptacle
7. Linen hamper
8. Pass window with shelf and sliding sash
9. Table, 24x36 inches
10. Nurses' desk with chart rack for 8 charts
11. Telephone outlet
12. Straight chair
13. Hook strip
14. Sink in counter with gooseneck spout and knee control
15. Counter, 36 inches high, with cabinets below
16. Instrument sterilizer, 4x6x16 inches
17. Wall cabinet
18. Single element hot plate
19. Refrigerator, 6 cubic feet
20. Counter, 36 inches high, open below
21. Stool
22. Chart rack for 2 charts
23. Incubator
24. Gown hook
25. Cubicle partitions, 5 feet 6 inches high, clear class in upper pannels

(NOTE: Where use of large incubators is contemplated cubicle size should be increased accordingly.)

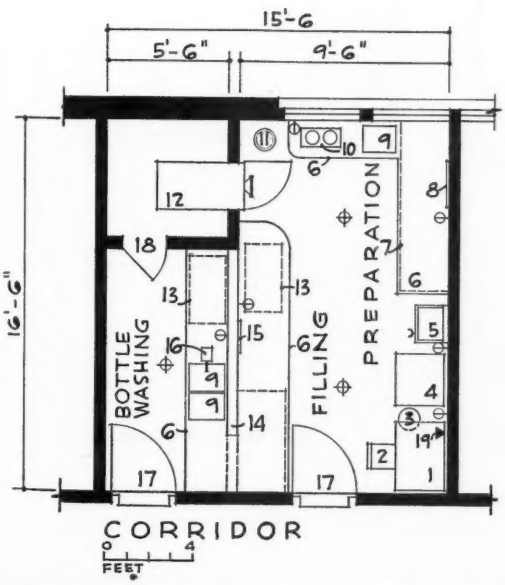
40—Nursery for a 50-Bed General Hospital



41—Nursery for a 100-Bed General Hospital (470 Live Births per Year)



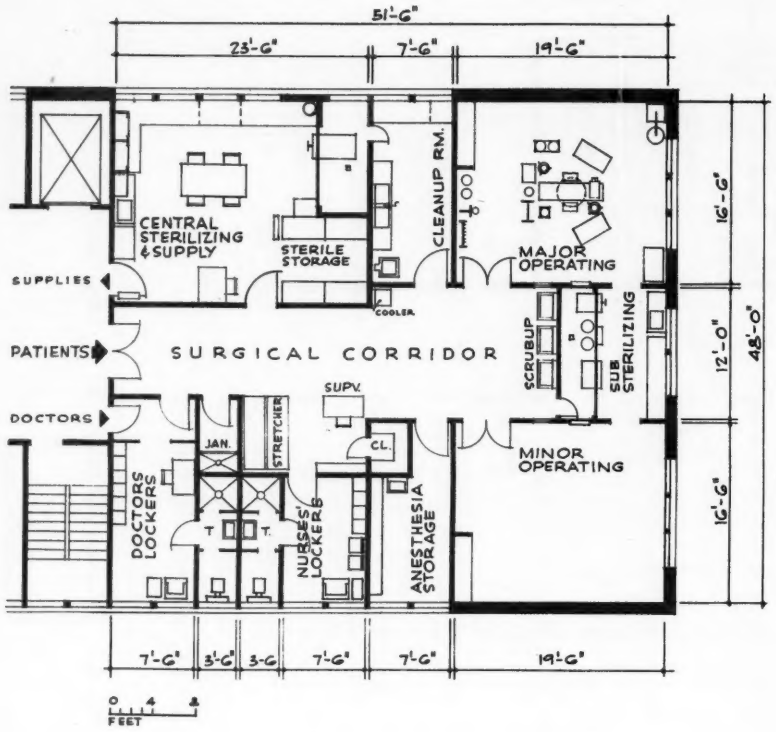
42—Nursery for a 200-Bed General Hospital (920 Live Births per Year)



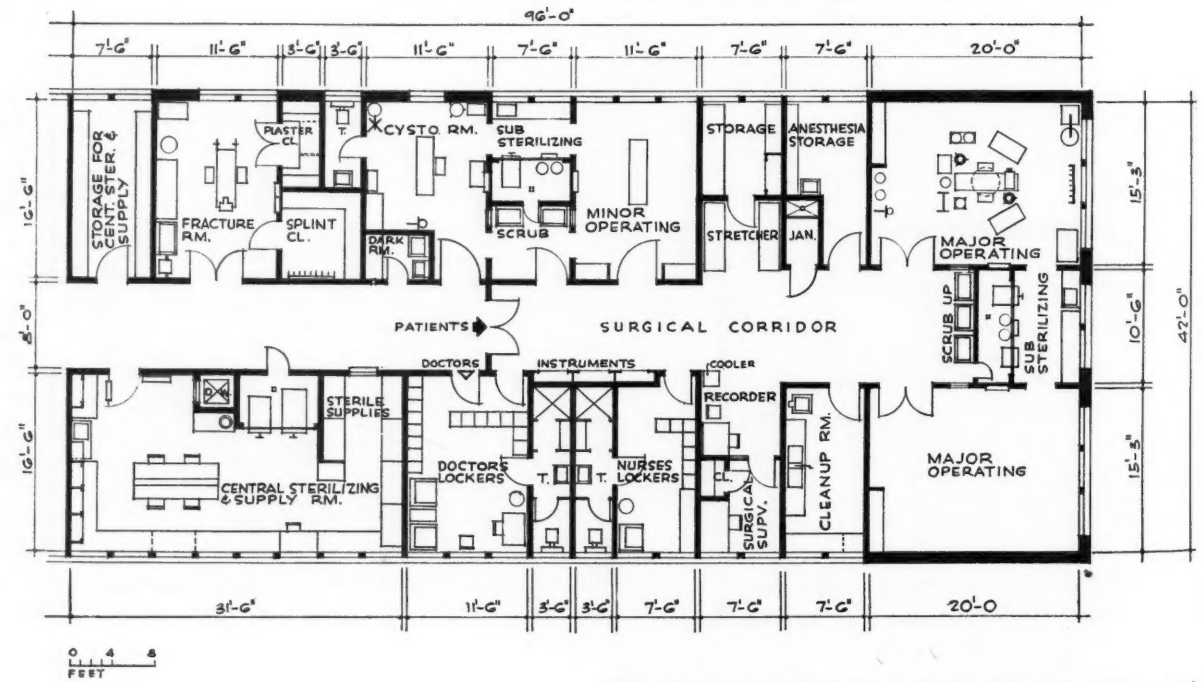
1. Desk
2. Chair
3. Waste paper receptacle
4. Refrigerator
5. Lavatory with knee control
6. Counter, 36 inches high
7. Cabinets under counter
8. Bulletin board, 26x24 inches
9. Sink
10. Two element hot plate
11. Sanitary waste receptacle
12. Rectangular pressure sterilizer, nickel clad
13. Milk cart
14. Partition, 5 feet high
15. Holder for formula record book
16. Electric bottle washer
17. Dutch door
18. Access door
19. Telephone outlet

43—Milk Room

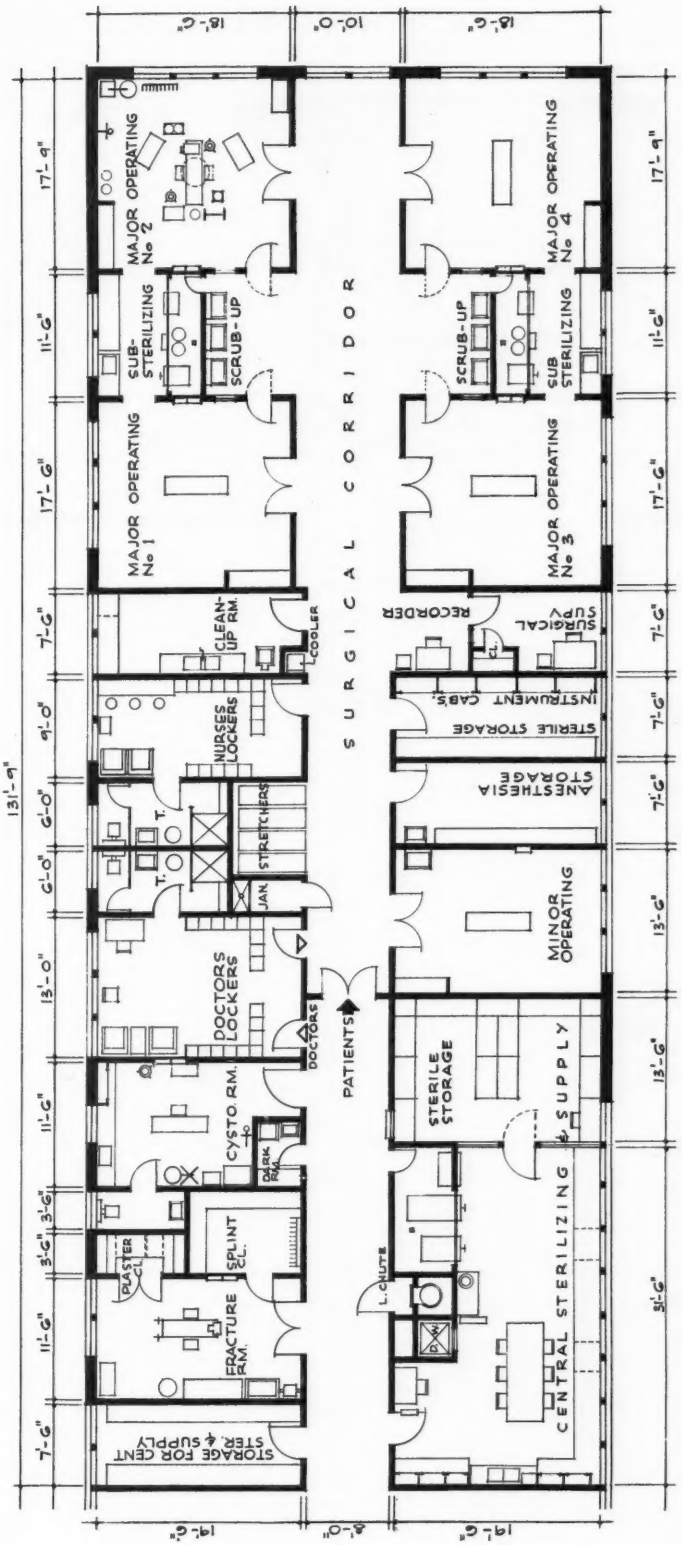
SURGICAL DEPARTMENT



44—Operating Suite for a 50-Bed General Hospital

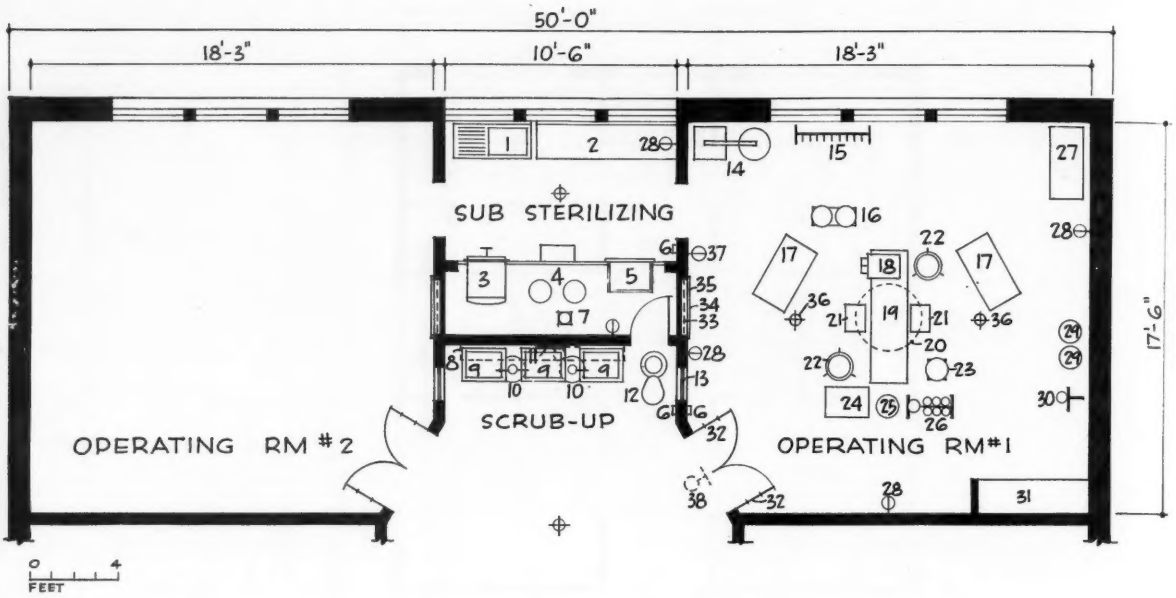


45—Operating Suite for a 100-Bed General Hospital



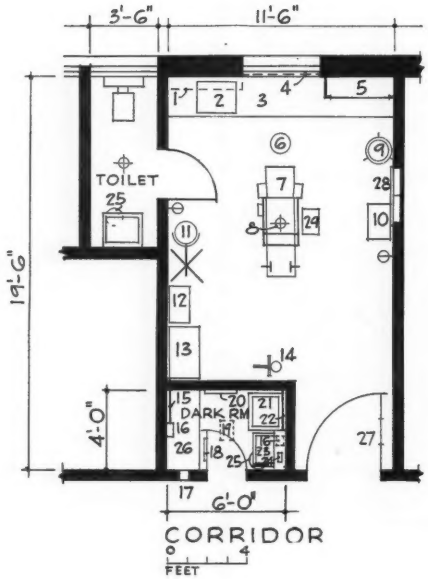
46—Operating Suite for a 200-Bed General Hospital

SURGICAL DEPARTMENT



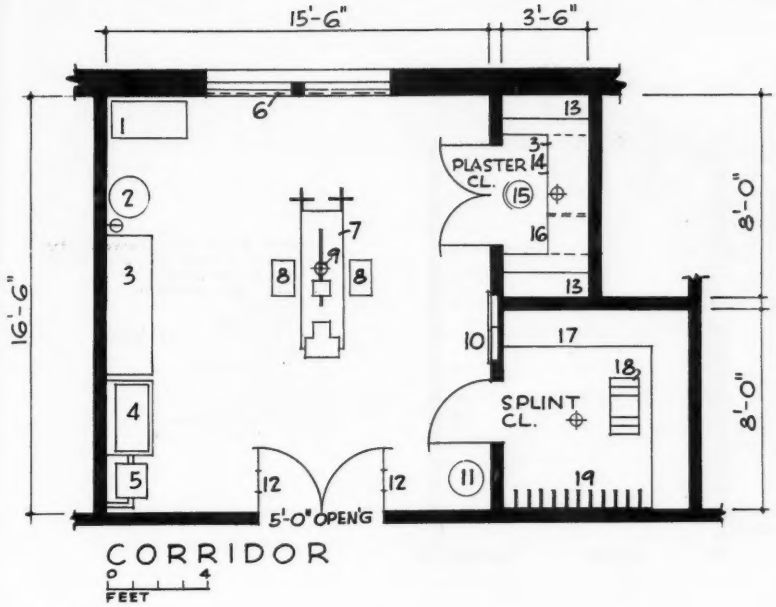
47—Operating Rooms

1. Sink and drainboard
2. Counter, 36 inches high, open below
3. High speed pressure sterilizer, 16x24 inches
4. Water sterilizers, 15 gallons each
5. Blanket and solution warmer
6. Mercury switch
7. Floor drain
8. Glass shelf over scrub sinks
9. Scrub sink
10. Soap dispenser
11. Clock
12. Alcohol dispenser
13. View window, clear glass
14. Portable emergency light
15. Sponge rack
16. Double basin stand
17. Instrument table, 24 x 48 inches
18. Mayo table
19. Operating table
20. Operating light
21. Footstool
22. Kick bucket
23. Single basin stand
24. Anesthetist's table
25. Anesthetist's stool
26. Anesthesia unit
27. Pack table
28. Explosion proof electric outlet
29. Adjustable stool
30. Irrigator stand
31. Adjustable open shelving, 18 inches wide
32. Vision panel
33. Clock and interval timer
34. Double recessed view box
35. Aspirator below view box
36. Flush ceiling fixture for general illumination
37. Explosion proof calling station, foot operated
38. Corridor dome light



1. Shelf
2. Sink in counter with gooseneck spout and knee control
3. Counter, 36 inches high, open below
4. Light proof shade
5. Wall cabinet
6. Adjustable stool
7. Urological x-ray table
8. Ceiling light
9. Kick bucket
10. Wheeled catheter tray
11. Examining light
12. Electric cautery
13. Urological instrument cabinet, 19 x 30 inches
14. Irrigator stand
15. Film hanger rack above counter
16. Safelight
17. Exhaust fan
18. Light proofed door with light proof louvre
19. Ceiling light, white and red
20. Towel bar
21. Developing tank, 18 x 22 inches
22. Film drying bracket for 12 films
23. Sink with shelf over
24. Timer
25. Waste paper receptacle
26. Counter, 36 inches high, with cabinets below
27. View panel
28. Double recessed view box
29. Footstool

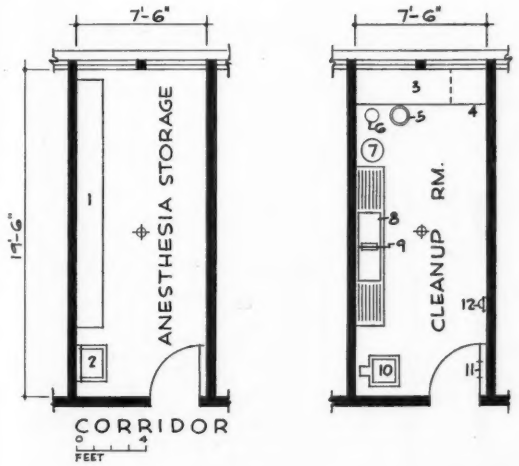
48—Cystoscopic Room



1. Instrument table, 18 x 36 inches
2. Galvanized iron can
3. Counter, 36 inches high, open below
4. Plaster sink
5. Plaster trap
6. Light proof shade
7. Fracture table
8. Footstool
9. Ceiling fixture
10. Double recessed view box
11. Linen hamper
12. Vision panel
13. Three shelves, 12 inches wide
14. Plaster drawer, 3 inches deep, open below
15. Adjustable stool with back
16. Plaster bin
17. Six shelves, 18 inches wide
18. Step ladder
19. Two rows of ¾ inch diameter dowels, 12 inches o.c., staggered; top row, 6 feet from floor, bottom row, 5 feet from floor

(NOTE: Corridor doors should be light proofed.)

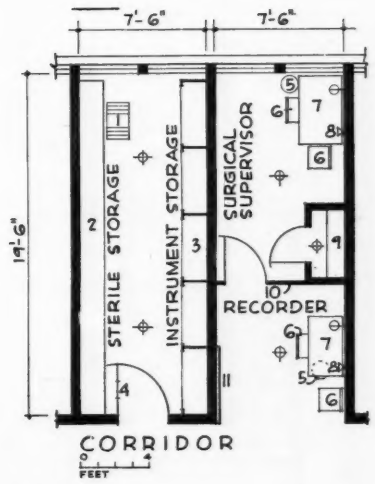
49—Fracture Room



50—Anesthesia Storage and Cleanup Room

1. Shelving 18 inches wide
2. Sink with gooseneck spout and knee or elbow control
3. Counter, 36 inches high, open below
4. Cabinet below counter, 2 feet wide
5. Sanitary waste receptacle
6. Waste paper receptacle
7. Linen hamper
8. Double compartment laundry tray with drainboards
9. Wringer
10. Clinical sink
11. Vision panel
12. Dome light and buzzer set 5 feet 6 inches from floor

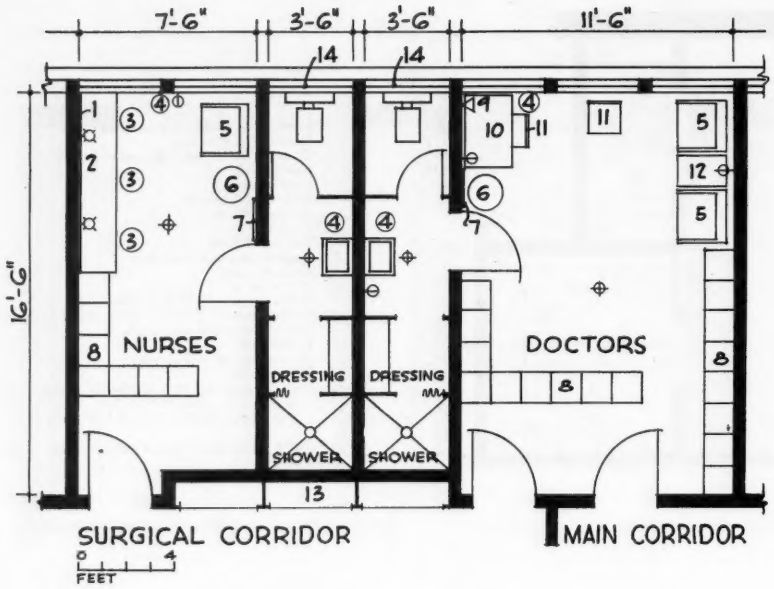
(NOTE: Radiator to be omitted in Anesthesia Room.)



51—Instrument and Sterile Supply Room, Surgical Supervisor and Recorder for a 200-Bed General Hospital

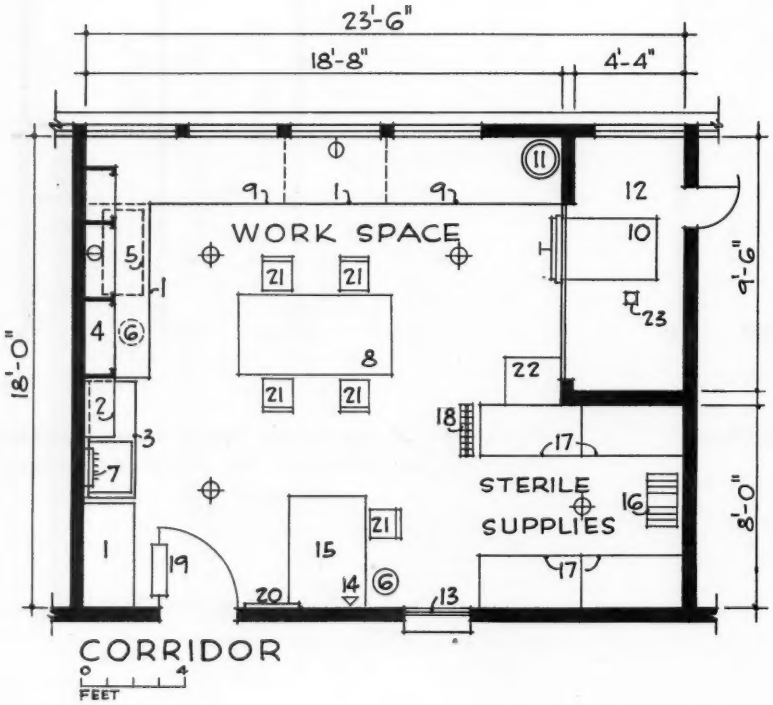
1. Step ladder
2. Shelving, 18 inches wide
3. Instrument cabinet
4. Vision panel
5. Waste paper receptacle
6. Straight chair
7. Desk
8. Telephone outlet
9. Shelving 12 inches wide
10. Glazed door and partition, clear glass
11. Blackboard

SURGICAL DEPARTMENT



1. Mirror, 84 x 24 inches, above counter
2. Counter, 30 inches high, open below
3. Stool, 18 inches high
4. Waste paper receptacle
5. Easy chair
6. Linen hamper
7. Bulletin board, 26 x 24 inches
8. Lockers
9. Telephone outlet
10. Desk
11. Straight chair
12. End table
13. Instrument cabinets
14. Obscure glass

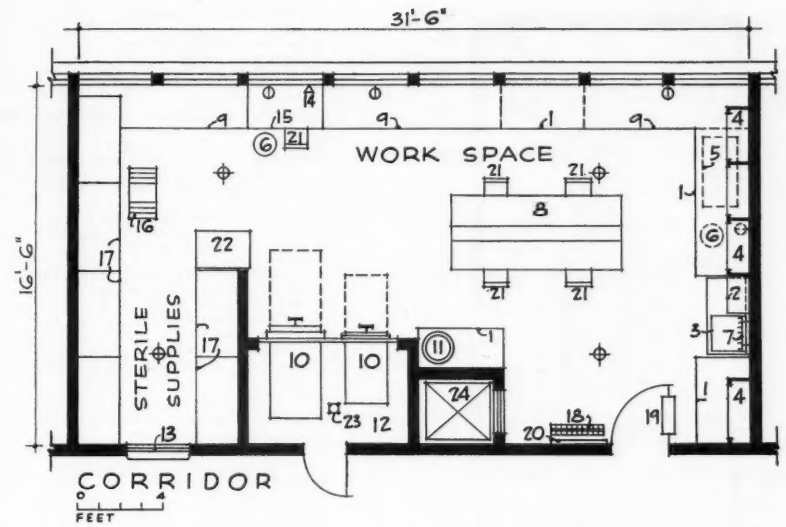
52—Doctors' and Nurses' Locker Rooms in Surgical Suite



1. Counter, 36 inches high, open below
2. Shelf
3. Sink and drainboard
4. Wall cabinet
5. Supply cart
6. Waste paper receptacle
7. Multiple rubber tube washer
8. Table, 42 x 72 inches
9. Counter, 36 inches high, cabinets and drawers below
10. Dressing sterilizer, 24 x 24 x 36 inches
11. Water still, capacity 5 gallons per hour
12. Ventilated mechanical space
13. Pass window
14. Telephone outlet
15. Desk
16. Step ladder
17. Sterile supply cabinets
18. Glove drying rack
19. Dutch door
20. Bulletin board, 26 x 24 inches
21. Straight chair
22. Hot air sterilizer, 18 x 14 x 14 inches
23. Floor drain

(NOTE: Convenient to this room provide a storage room for unsterile supplies and equipment.)

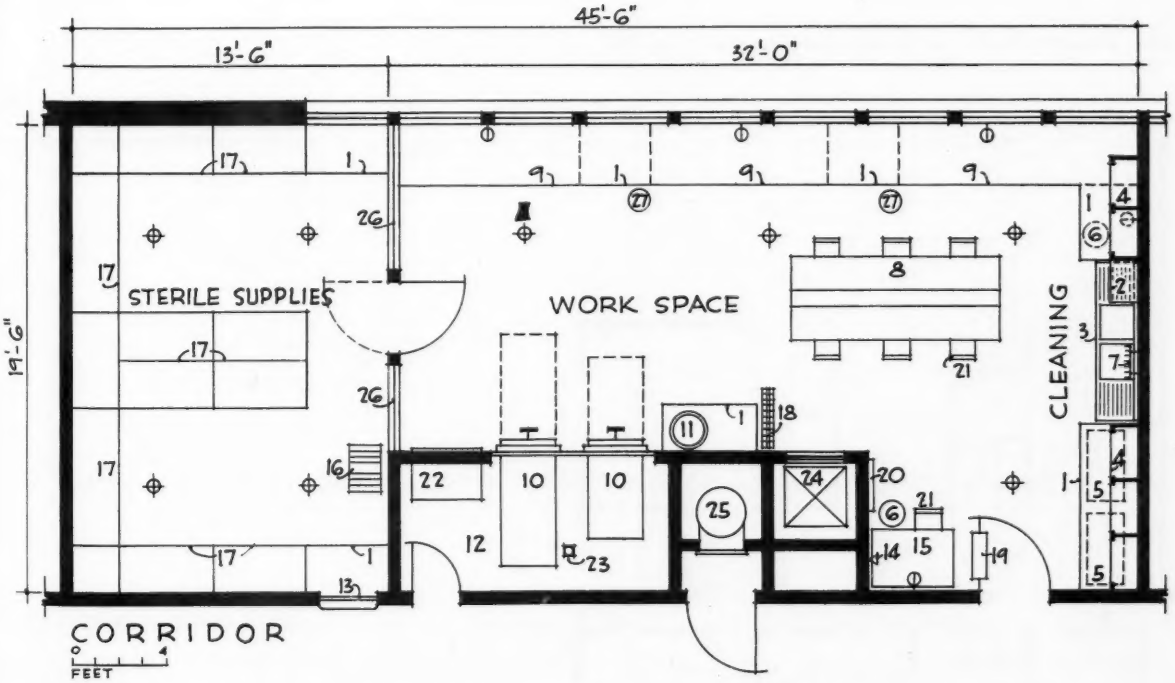
53—Central Sterilizing and Supply Room for a 50-Bed General Hospital



1. Counter, 36 inches high, open below
2. Shelf
3. Sink and drainboard
4. Wall cabinet
5. Supply cart
6. Waste paper receptacle
7. Multiple rubber tube washer
8. Table with shelf over, 42 x 96 inches
9. Counter, 36 inches high, cabinets and drawers below
10. Dressing sterilizers; 1—24 x 24 x 36 inches—1—20 x 36 inches
11. Water still, capacity 5 gallons per hour
12. Ventilated mechanical space
13. Pass window
14. Telephone outlet
15. Built in desk, 30 inches high with drawer
16. Step ladder
17. Sterile supply cabinet
18. Glove drying rack
19. Dutch door
20. Bulletin board, 26 x 24 inches
21. Straight chair
22. Hot air sterilizer, 24 x 14 x 14 inches
23. Floor drain
24. Dumb waiter

(NOTE: Convenient to this room provide a storage room for unsterile supplies and equipment.)

54—Central Sterilizing and Supply Room for a 100-Bed General Hospital

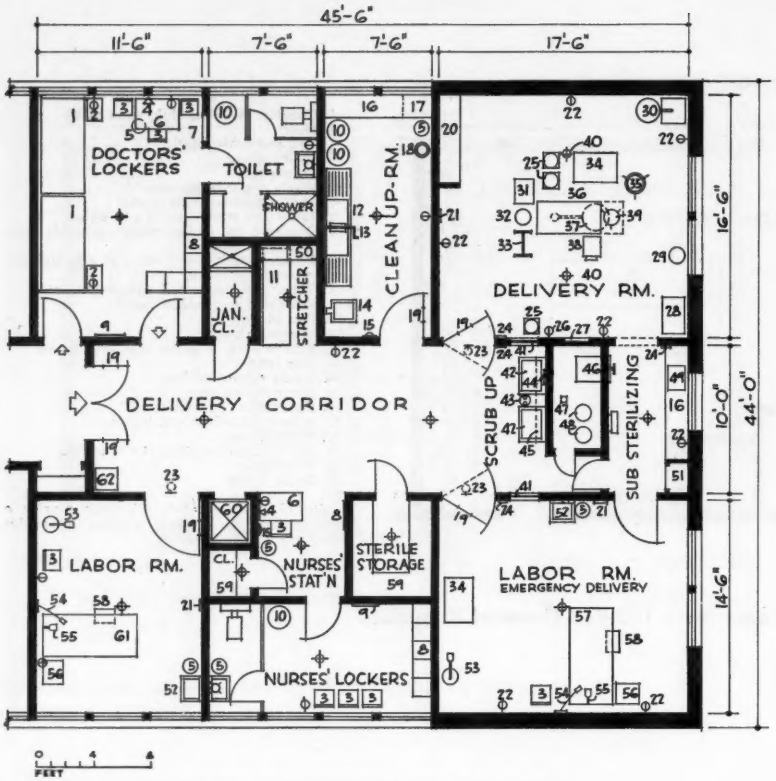


55—Central Sterilizing and Supply Room for a 200-bed General Hospital

1. Counter, 36 inches high, open below
2. Shelf
3. Sink and drainboard
4. Wall cabinet
5. Supply cart
6. Waste paper receptacle
7. Multiple rubber tube washer
8. Table with shelf over, 42 x 96 inches
9. Counter, 36 inches high, cabinets and drawers below
10. Dressing sterilizers; 1—24 x 36 x 48 inches—1—24 x 24 x 36 inches
11. Water still, capacity 5 gallons per hour
12. Ventilated mechanical space
13. Pass window
14. Telephone outlet
15. Desk
16. Step ladder
17. Sterile supply cabinet
18. Glove drying rack
19. Dutch door
20. Bulletin board, 26 x 24 inches
21. Straight chair
22. Hot air sterilizer, 30 x 24 x 18 inches
23. Floor drain
24. Dumb waiter
25. Laundry chute
26. Glazed partitions
27. Adjustable stool

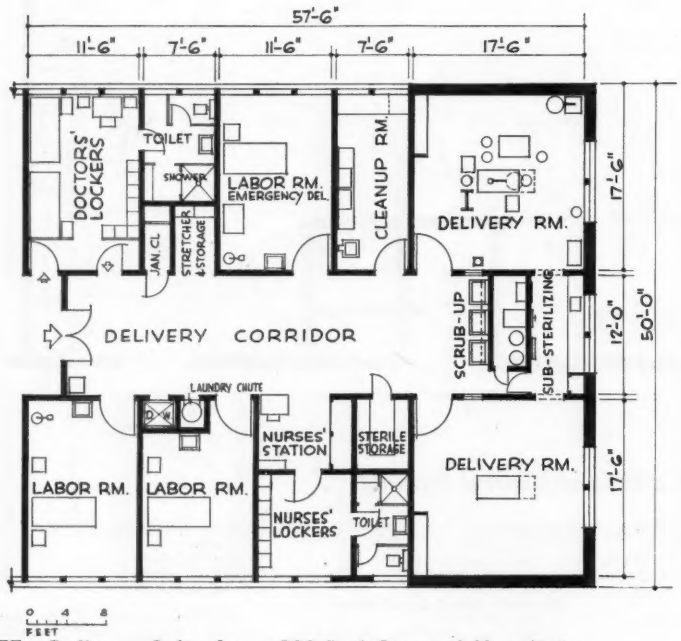
(NOTE: Convenient to this room provide a storage room for unsterile supplies and equipment.)

OBSTETRICS DEPARTMENT

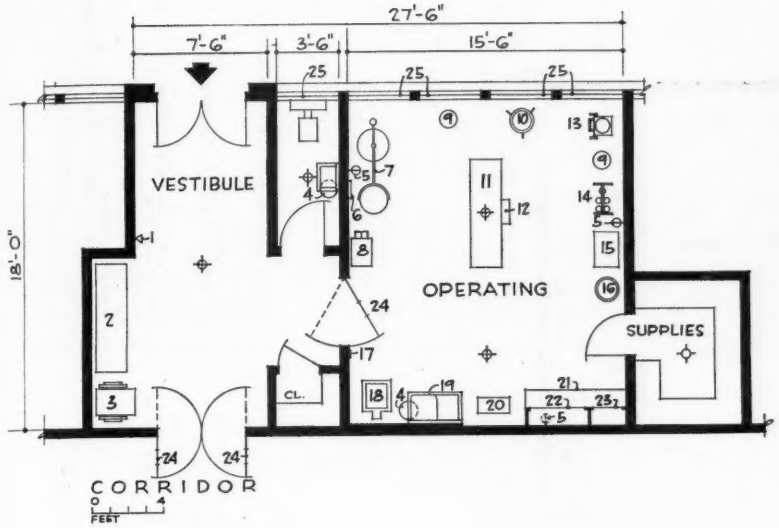


56—Delivery Suite for a 100-Bed General Hospital

1. Combination box spring and mattress on legs
2. Night table
3. Straight chair
4. Telephone outlet
5. Waste paper receptacle
6. Table
7. Double recessed view box
8. Lockers
9. Bulletin board, 26 x 24 inches
10. Linen hamper
11. Wheel stretcher
12. Double compartment laundry tray with drainboards
13. Wringer
14. Clinical sink with bed pan flushing attachment
15. Dome light and buzzer set 5 feet 6 inches from floor
16. Counter 36 inches high, open below
17. Cabinet below counter, 2 feet wide
18. Sanitary waste receptacle
19. Vision panel
20. Adjustable open shelving, 18 inches wide
21. Clock with sweep second hand
22. Explosion proof outlet
23. Corridor dome light
24. Mercury switch
25. Single basin stand
26. Explosion proof calling station, foot operated
27. Aspirator
28. Heated bassinet
29. Adjustable stool
30. Portable emergency light
31. Anesthetists' table
32. Anesthetists' stool
33. Anesthesia unit
34. Instrument table
35. Kick bucket
36. Delivery table
37. Obstetrical light
38. Mayo table
39. Kick basin
40. Flush ceiling fixture for general illumination
41. View window, clear glass
42. Scrub sink
43. Soap dispenser
44. Clock
45. Shelf over scrub sinks
46. High speed pressure sterilizer, 16 x 24 inches
47. Floor drain
48. Water sterilizers, 15 gal. each
49. Sink in counter
50. Wall cabinet set 42 inches from floor
51. Blanket and solution warmer
52. Lavatory with gooseneck spout and knee control
53. Examining light
54. Nurses' calling station with duplex receptacle
55. Bed light
56. Bedside cabinet
57. Obstetrical bed
58. Foot stool
59. Shelving
60. Dumb waiter connecting with central sterilizing room
61. Labor bed
62. Water cooler

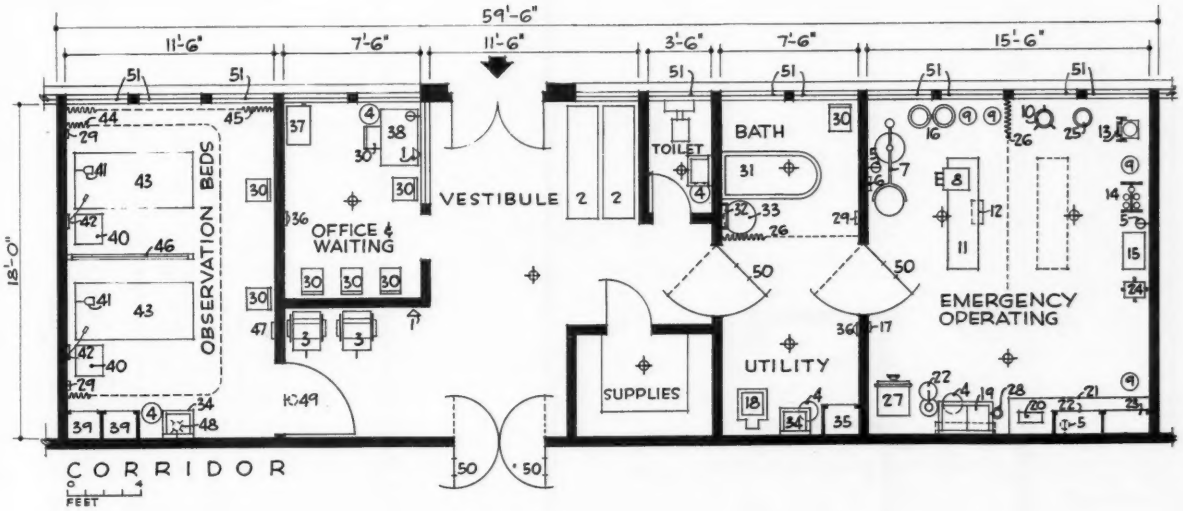


57—Delivery Suite for a 200-Bed General Hospital



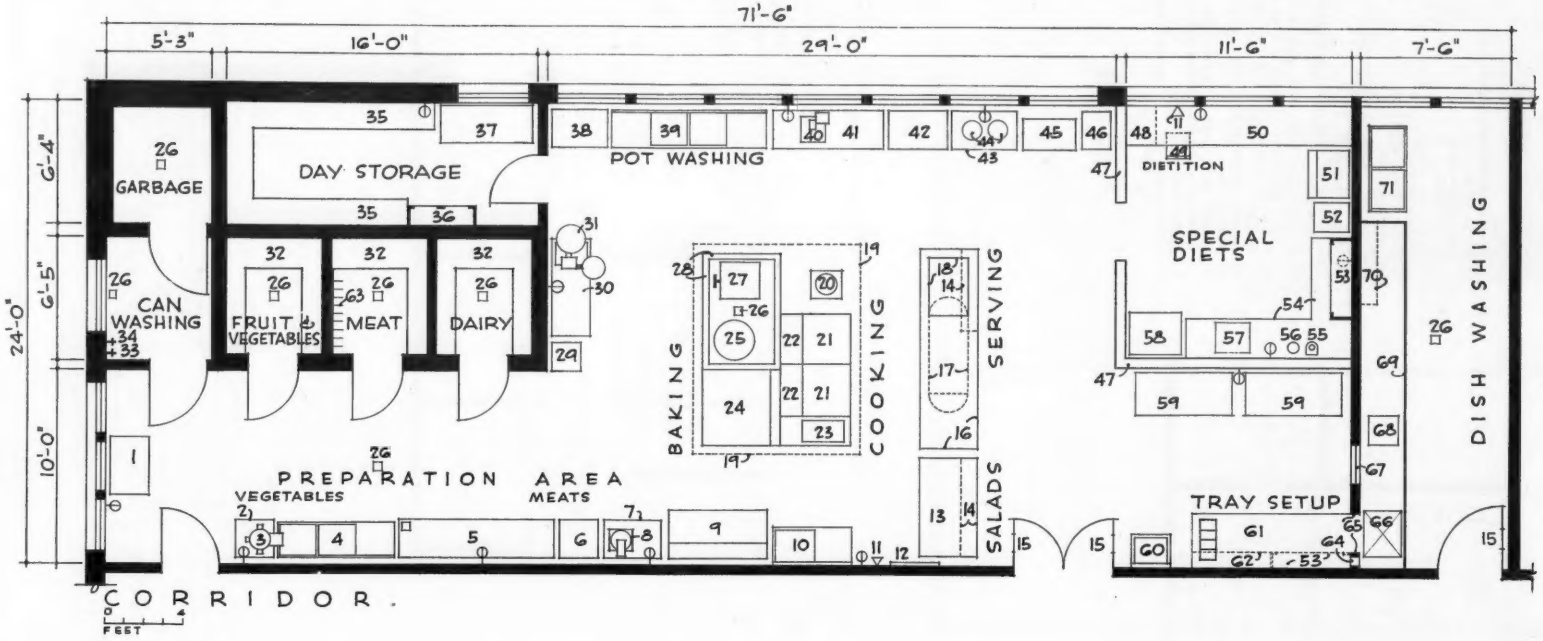
1. Telephone outlet
2. Wheel stretcher
3. Wheel chair
4. Waste paper receptacle
5. Explosion proof outlet
6. Clock
7. Portable emergency light
8. Mayo table
9. Adjustable stool
10. Kick bucket
11. Examining table
12. Foot stool
13. Resuscitating apparatus
14. Anesthesia unit
15. Instrument table, 16 x 24 inches
16. Single basin stand
17. Mercury switch
18. Clinical sink with bed pan flushing attachment
19. Combination instrument and scrub sink with gooseneck spout and knee control
20. Instrument sterilizer, 9 x 10 x 20 inches, on stand
21. Counter, 36 inches high with cabinets below
22. Wall cabinet
23. Locked wall cabinet with inner locked narcotic compartment and inside light
24. Vision panel
25. Obsure glass

58—*Small Emergency Suite*



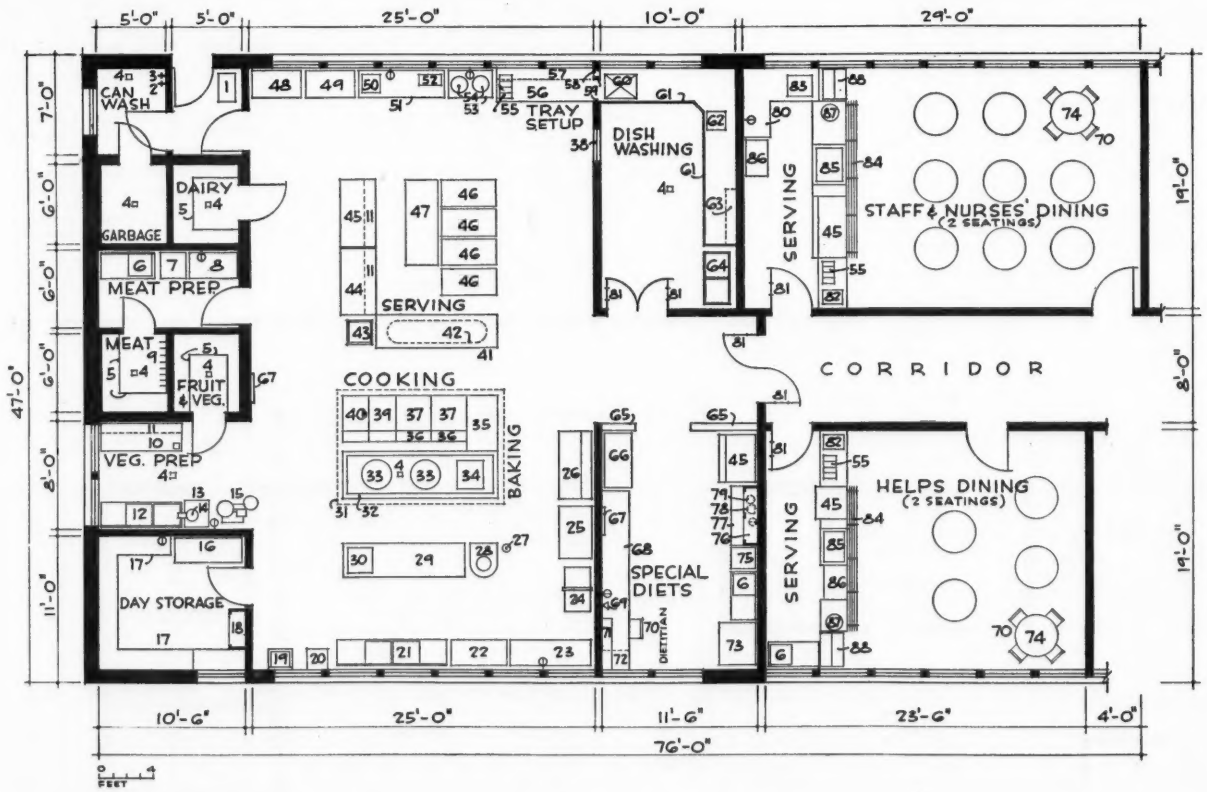
59—*Large Emergency Suite*

1. Telephone outlet
2. Wheel stretcher
3. Wheel chair
4. Waste paper receptacle
5. Explosion proof outlet
6. Clock
7. Portable emergency light
8. Mayo table
9. Adjustable stool
10. Kick bucket
11. Examining table
12. Foot stool
13. Resuscitating apparatus
14. Anesthesia unit
15. Instrument table, 16 x 24 inches
16. Double basin stand
17. Mercury switch
18. Clinical sink with bed pan flushing attachment
19. Combination instrument and scrub sink with gooseneck spout and knee control
20. Instrument sterilizer, 4 x 6 x 16 inches
21. Counter, 36 inches high with cabinets below
22. Wall cabinet
23. Locked wall cabinet with inner locked narcotic compartment and inside light
24. Leg stand
25. Sanitary waste receptacle
26. Curtain and rod
27. High speed pressure sterilizer, 16 x 24 inches
28. Single soap dispenser
29. Hook strip
30. Straight chair
31. Shallow tub
32. Towel bar
33. Linen hamper
34. Lavatory with gooseneck spout and knee control
35. Blanket warmer
36. Dome light and buzzer, set 5 feet 6 inches from floor
37. Filing cabinet, letter size, 4 drawers
38. Desk
39. Locker
40. Bedside cabinet
41. Bed light
42. Nurses' calling station with duplex receptacle
43. Adjustable hospital bed
44. Cubicle curtain and rod
45. Sliding window curtain
46. Cubicle partition, 7 feet high with obscure glass in upper panels
47. Night light
48. Wall bracket light, switch controlled
49. Corridor dome light
50. Vision panel
51. Obscure glass



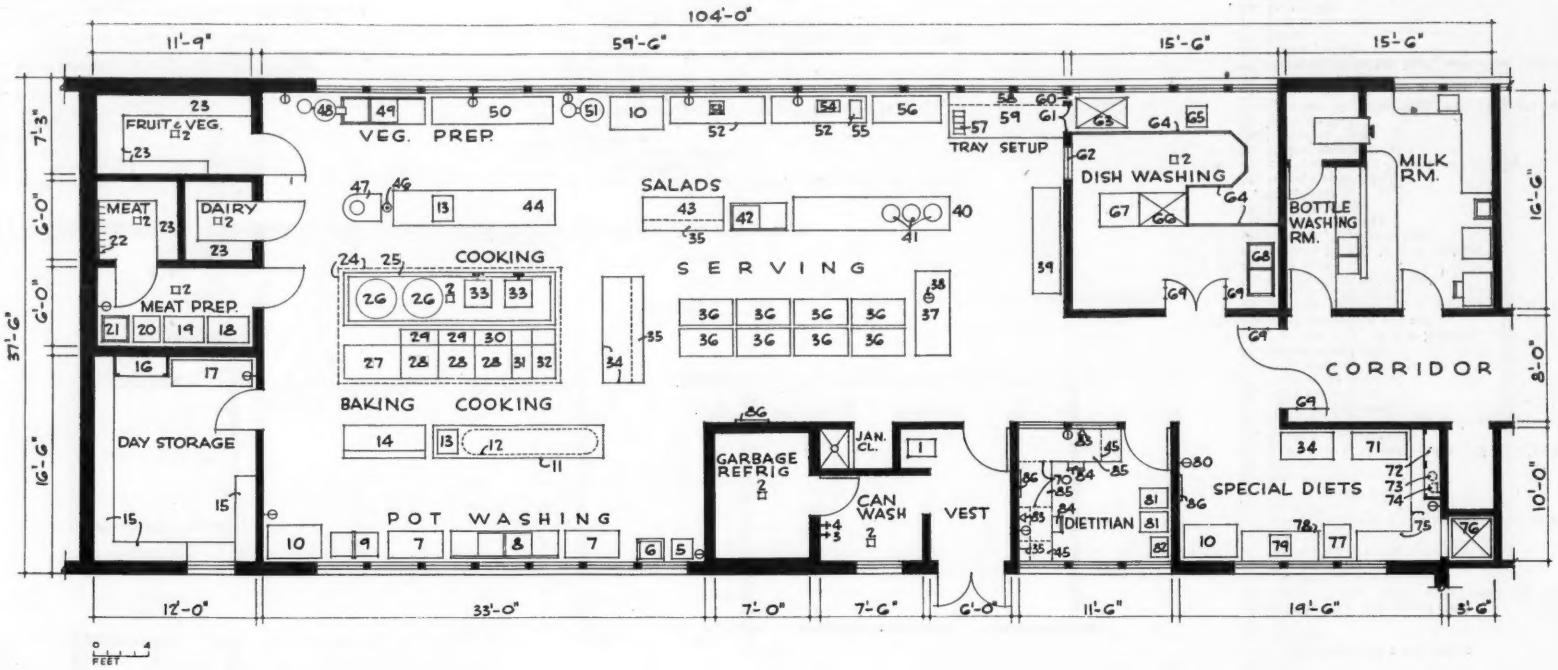
60—Kitchen for a 50-Bed General Hospital Using Central Tray System

1. Platform scale, 500 lb. capacity
2. Table, 24 x 24 inches
3. Peeler, 15 lb. capacity, bench type
4. Double compartment sink and single drainboard
5. Work table, 24 x 96 inches with vegetable bins and refuse can space below
6. Meat block, 24 x 24 inches
7. Table, 24 x 36 inches
8. Food mixer, 20 quart capacity, bench type
9. Baker's table, 30 x 60 inches, with bins and drawers below, spice bins above
10. Sink and drainboard
11. Telephone outlet
12. Bulletin board, 26 x 24 inches
13. Refrigerator with wood work top
14. Shelf over
15. Vision panel
16. Cook's table, 36 x 120 inches
17. Pot rack
18. Bain Marie
19. Hood
20. Cereal cooker
21. Range with oven
22. Elevated broiler
23. Fryer
24. Roasting and baking oven (2 sections)
25. Kettle, 20 gallon capacity
26. Floor drain
27. Steamer (2 compartments)
28. Curb
29. Water cooler
30. Table, 24 x 60 inches
31. Food cutter, 14 inch bowl
32. Refrigerator shelving
33. Hot water outlet
34. Steam outlet
35. Shelving, 18 inches wide, first shelf 36 inches above floor
36. Locked dish cabinet
37. Frozen food locker
38. Pot cabinet
39. Double compartment sink and drainboards
40. Meat slicer
41. Table, 24 x 60 inches with cabinet below
42. Bread box, 24 x 36 inches with cutting top
43. Urn stand, 24 x 42 inches
44. Coffee Urns, 5 gallons coffee, 10 gallons water
45. Ice cream cabinet
46. Tray table, 18 x 24 inches
47. Partition, 3 feet high
48. Filing cabinet below
49. Straight chair
50. Counter, 30 inches high, open below
51. Steam table
52. Domestic range
53. Wall cabinet
54. Counter, 36 inches high with cabinets below
55. Juice Extractor
56. Beverage mixer
57. Sink in counter
58. Refrigerator, 6 cubic feet capacity
59. Tray trucks
60. Lavatory
61. Counter, 36 inches high, with open shelves below
62. Three shelves over
63. Meat hooks
64. Rack return slot
65. Open pass window
66. Dish washing machine, 2,500 pieces per hour
67. Vision window
68. Pre-rinse sink, 18 x 18 inches
69. Soiled dish table
70. Shelf for soiled glasses
71. Double compartment sink, 24 x 24 x 14 inches each



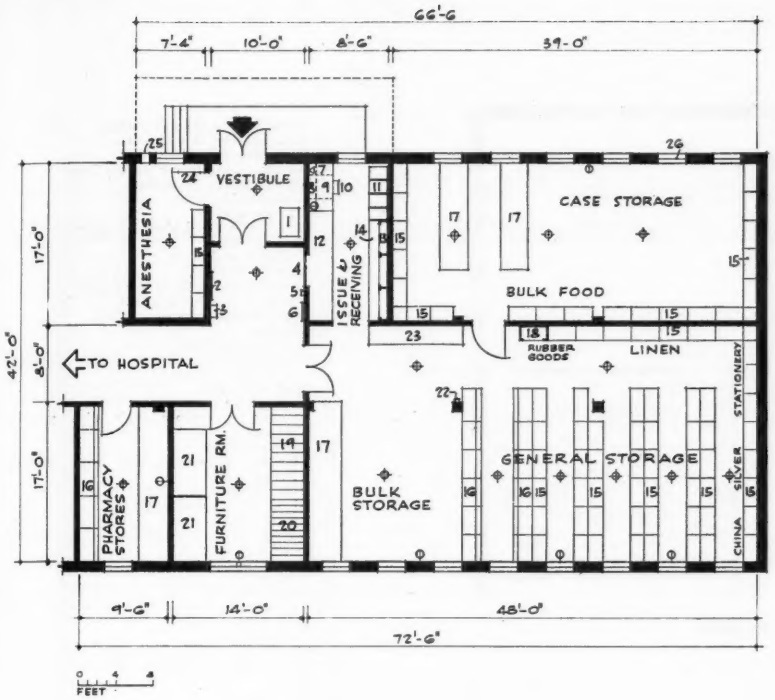
61—*Kitchen for a 100-Bed General Hospital Using Central Tray System*

1. Platform scale, 500 lb. capacity
2. Hot water outlet
3. Steam outlet
4. Floor drain
5. Refrigerator shelving
6. Sink and drainboard
7. Meat block, 24 x 24 inches
8. Table, 24 x 42 inches
9. Meat Hooks
10. Preparation table, 24 x 72 inches, with vegetable bins and refuse can space below
11. Shelf over
12. Double compartment sink and single drainboard
13. Table, 24 x 24 inches
14. Peeler, 15 lb. capacity, bench type
15. Food cutter, 15 inch bowl
16. Frozen food locker
17. Shelving, 18 inches wide, first shelf 36 inches above floor
18. Locked dish cabinet
19. Lavatory
20. Water cooler
21. Double compartment sink and drainboards
22. Pot cabinet
23. Table, 24 x 72 inches
24. Pan rack
25. Refrigerator, 29 cubic feet capacity
26. Baker's table, 30 x 60 inches, with bins and drawers below, spice bins above
27. Floor outlet, (electric)
28. Food mixer, 30 quart capacity
29. Cook's table, 30 x 108 inches
30. Sink in table
31. Hood
32. Curb
33. Kettles, 30 gallon capacity
34. Steamer, 3 compartments
35. Oven, 4 compartments
36. Salamander
37. Range with oven
38. Vision window
39. Spreader plate
40. Fryer
41. Cook's table, 30 x 108 inches
42. Pot rack
43. Sink
44. Refrigerator with wood work top
45. Steam table with dish warming compartment below
46. Open tray trucks
47. Heated food truck
48. Ice cream cabinet
49. Bread box, 24 x 42 inches with wood cutting top
50. Meat slicer
51. Table, 24 x 72 inches
52. Egg boiler
53. Urn stand
54. Coffee urns, 10 gals. coffee, 10 gals. water
55. Silver compartments
56. Counter, 36 inches high with open shelves below
57. Three shelves over
58. Rack return slot
59. Opan pass window
60. Dish washer, 3,500 pieces per hour
61. Soiled dish table
62. Pre-rinse sink, 18 x 18 inches
63. Shelf for soiled glasses
64. Double compartment sink, 24 x 24 x 14 inches each
65. Partition, 36 inches high
66. Tray rack
67. Bulletin board, 26 x 24 inches
68. Counter, 30 inches high
69. Telephone outlet
70. Straight chair
71. Shelf over
72. Filing cabinet below
73. Refrigerator, 12 cubic feet capacity
74. Dining room table
75. Domestic range
76. Wall cabinet
77. Counter, 36 inches high, with cabinets below
78. Juice extractor
79. Beverage mixer
80. Counter, 36 inches high, with open shelving below
81. Vision panels
82. Trays
83. Sink in counter
84. Tray slide
85. Cold pan, glass shelf over
86. Ice cream cabinet
87. Coffee urn, 4 gallons
88. Water cooler



62—*Kitchen for a 200-Bed General Hospital Using Central Tray Service*

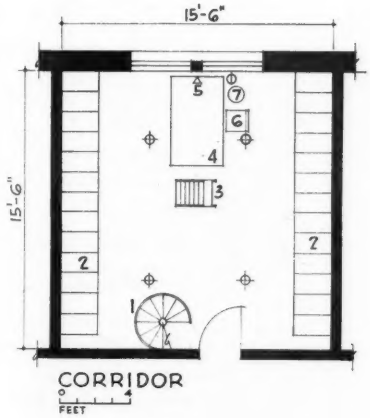
1. Platform scale, 500 lb. capacity
2. Floor drain
3. Hot water outlet
4. Steam outlet
5. Water cooler
6. Lavatory
7. Pot cabinet, 24 x 48 inches
8. Double compartment sink with drainboards
9. Pan rack
10. Refrigerator, 29 cubic feet capacity
11. Cook's table, 30 x 150 inches
12. Pot rack
13. Sink in table
14. Baker's table, 30 x 72 inches, with bins and drawers below, spice bins above
15. Shelving, 18 inches wide, first shelf 36 inches above floor
16. Locked dish cabinet
17. Frozen food locker
18. Fish box, 24 x 36 inches
19. Table, 24 x 36 inches
20. Meat block, 24 x 24 inches
21. Sink, 24 x 24 inches
22. Meat hooks
23. Refrigerator shelving
24. Hood
25. Curb
26. Kettle, 80 gallon capacity
27. Oven, 3 compartments
28. Range with oven
29. Salamander
30. Shelf
31. Spreader plate
32. Fryer
33. Steamer, 2 compartments
34. Steam table with dishwarming compartment below
35. Shelf over
36. Open tray trucks
37. Heated tray truck
38. Overhead electric outlet
39. Ice cream making and dispensing unit
40. Table, 30 x 138 inches
41. Coffee urns
42. Sink and drainboard
43. Salad table, 30 x 72 inches
44. Cook's table, 30 x 144 inches
45. Filing cabinet below
46. Floor outlet, (electric)
47. Food mixer, 60 qt. capacity
48. Peeler, 30 lb. capacity
49. Double compartment sink and single drainboard
50. Table, 24 x 108 inches
51. Food cutter, 15 inch bowl
52. Table, 24 x 84 inches
53. Meat slicer
54. Egg boiler
55. Toaster
56. Bread box, 24 x 60 inches with wood cutting top
57. Silver compartments
58. Shelving over
59. Counter, 36 inches high with open shelving below
60. Rack return slot
61. Open pass window
62. Vision window
63. Dishwasher, 6,000 pieces per hour
64. Soiled dish table
65. Pre-rinse sink, 18 x 18 inches
66. Glass washer
67. Clean glass table
68. Double compartment sink, 24 x 24 x 14 inches
69. Vision panel
70. Cabinet below counter
71. Tray rack
72. Wall cabinet
73. Juice extractor
74. Beverage mixer
75. Counter, 36 inches high, with cabinets below
76. Dumb waiter
77. Range with oven
78. Counter, 36 inches high, open below
79. Sink in counter
80. Electric outlet for cart
81. Filing cabinet
82. Locker
83. Telephone outlet
84. Straight chair
85. Counter, 30 inches high
86. Bulletin board, 26 x 24 inches



1. Platform scale flush with floor
2. Time card rack
3. Time clock
4. Rolling curtain
5. Push button
6. Bulletin board, 26 x 24 inches
7. Telephone outlet
8. Shelf
9. Counter, 30 inches high with drawers
10. Straight chair
11. Filing cabinet
12. Counter, 42 inches high, open below
13. Locked wall cabinets
14. Counter, 36 inches high with locked cabinets below
15. Adjustable steel shelving, open type, 18 inches deep
16. Adjustable steel shelving with backs, upper shelves 18 inches deep, lower shelves 24 inches deep
17. Wood platform raised 8 inches from floor
18. Steel cabinet with shelving and doors
19. Bed spring bins for 10 springs
20. Bed head and foot bins for 10 sets
21. Mattress rack for 5 mattresses
22. Buzzer
23. Counter with one shelf below
24. Louvred door
25. Vent at floor level
26. All windows to be barred

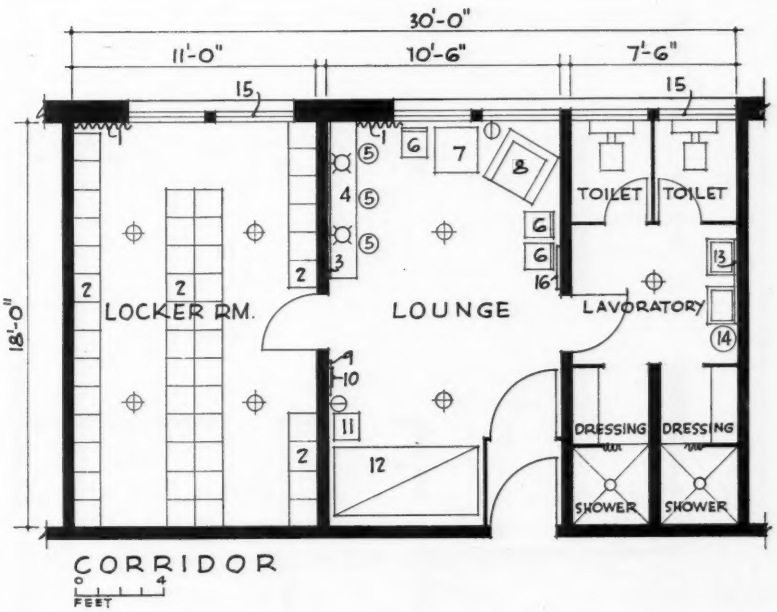
(NOTE: The size of the central storeroom and proportions of its various units will vary with each individual hospital. This plan shows the relationship of the units and generally the type of storage facilities required for each.)

63—Central Storeroom for a 100-Bed General Hospital



64—Record Storage for a 100-Bed General Hospital

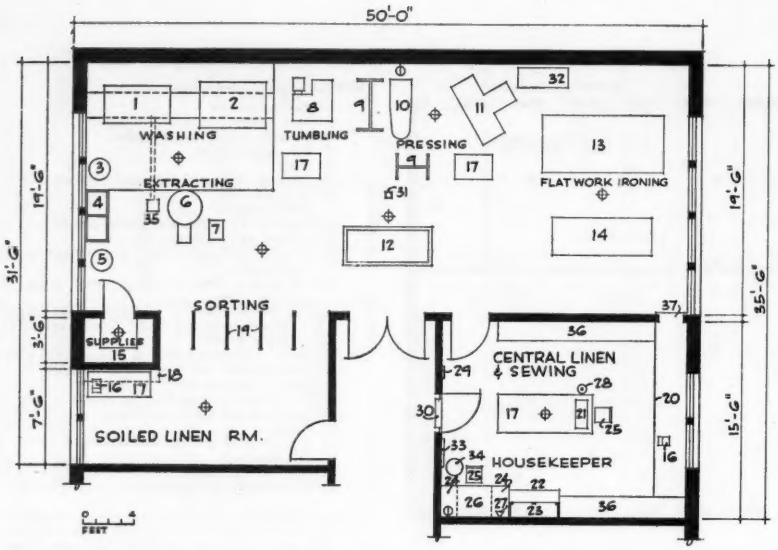
1. Spiral stairway up to record room
2. Transfer files
3. Step ladder
4. Work table, 36 x 60 inches
5. Telephone outlet
6. Straight chair
7. Waste paper receptacle



65—Nurses' Locker Room for a 100-Bed General Hospital

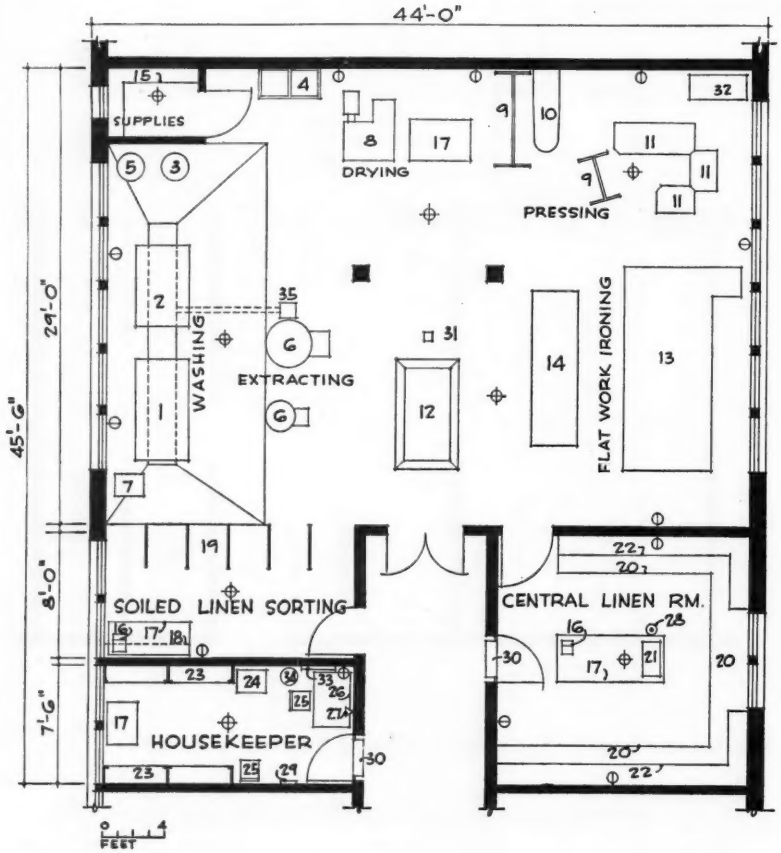
1. Sliding window curtain
2. Lockers, 15 x 15 x 60 inches
3. Mirror, 84 x 24 inches above counter
4. Counter, 30 inches high, open below
5. Stool, 18 inches high
6. Straight chair
7. Lamp table
8. Easy chair
9. Full length mirror
10. Clock
11. End table
12. Combination box spring and mattress with legs
13. Mirrors over lavatories
14. Waste paper receptacle
15. Obscure glass
16. Bulletin board, 26 x 24 inches

(NOTE: Female help locker room is similar.)



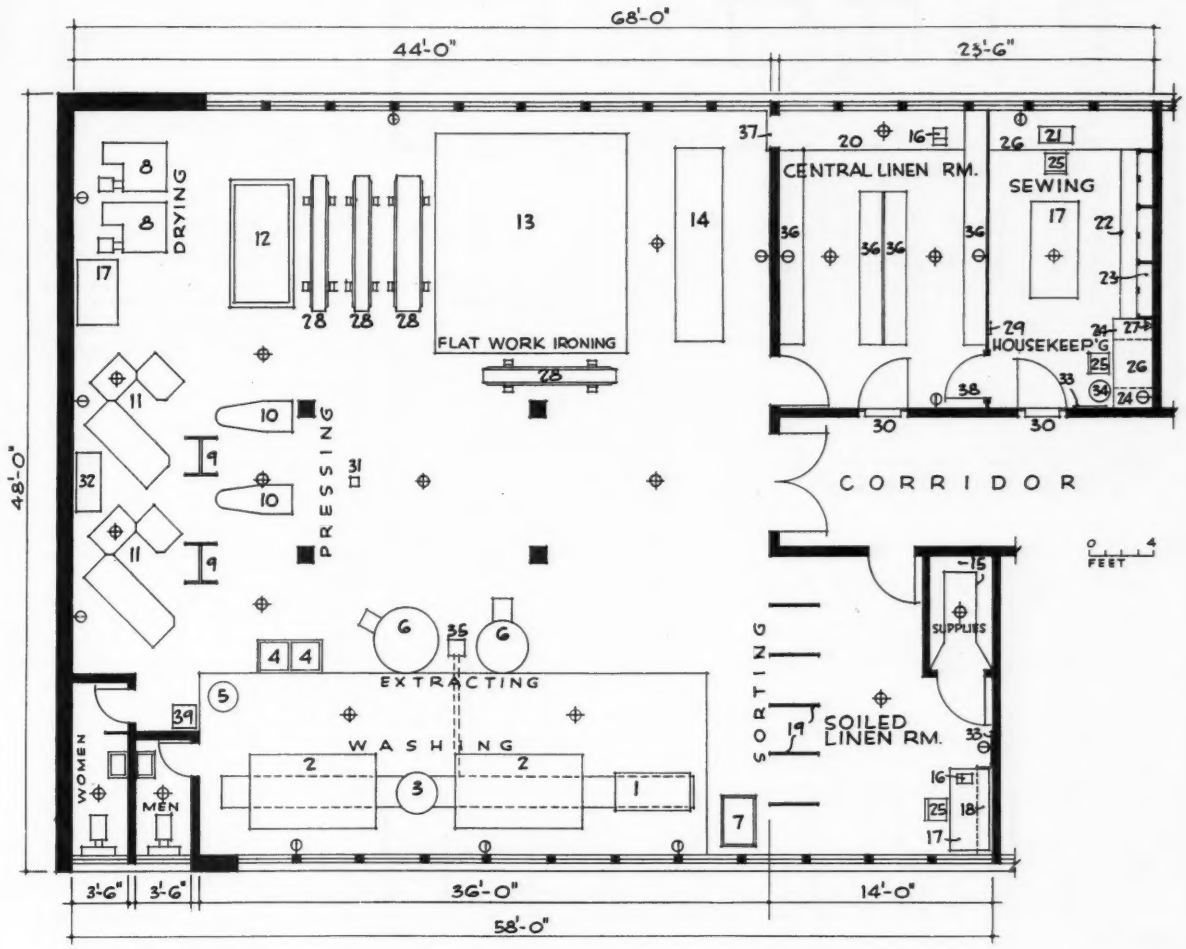
66—Laundry for a 50-Bed General Hospital

1. Metal washer, 24 x 36 inches
2. Metal washer, 36 x 36 inches
3. Soap tank, 30 gallons
4. Double compartment laundry trays
5. Starch cooker, 15 gallons
6. Extractor, 26 inches
7. Platform scale
8. Tumbler, 36 x 18 inches
9. Uniform rack
10. Ironing board
11. Press, 51 inches
12. Shakeout table with sloping sides
13. Flat work ironer, 100 inches
14. Table, 36 x 96 inches
15. Shelving
16. Marking machine
17. Tables, 2—24 x 36 inches, 1—24 x 60 inches, 1—36 x 90 inches
18. Shelf over table
19. Sorting bins
20. Counter, 36 inches high with shelving below
21. Sewing machine
22. Counter, 30 inches high with cabinets below
23. Wall cabinet
24. Filing cabinets below counter
25. Straight chair
26. Counter 30 inches high, open below with drawers
27. Telephone outlet
28. Floor outlet
29. Hook Strip
30. Dutch door
31. Floor drain
32. Compressor
33. Bulletin board, 26 x 24 inches
34. Waste paper receptacle
35. Sump
36. Shelving with bins
37. Pass window



67—Laundry for a 100-Bed General Hospital

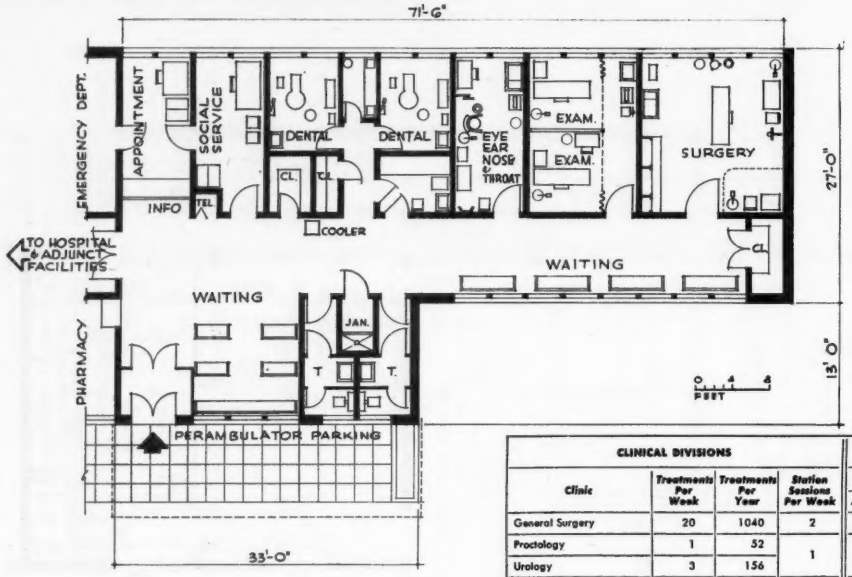
1. Metal washer, 36 x 54 inches
2. Metal washer, 36 x 36 inches
3. Soap tank, 30 gals.
4. Double compartment laundry trays
5. Starch cooker, 15 gals.
6. Extractor, 1—17 inch, and 1—26 inch
7. Platform scale
8. Tumbler, 36 x 30 inches
9. Uniform rack
10. Ironing board
11. Utility press
12. Shakeout table with sloping sides
13. Flat work ironer, 2 roll, 120 inches
14. Table, 36 x 120 inches
15. Shelving
16. Marking machine
17. Tables, 1—24 x 30 inches, 1—24 x 64 inches, 1—36 x 84 inches, 1—32 x 48 inches
18. Shelf over table
19. Sorting bins
20. Counter, 36 inches high with shelving below
21. Sewing machine
22. Shelving with bins
23. Wall cabinet
24. Filing cabinet
25. Straight chair
26. Desk
27. Telephone outlet
28. Floor outlet
29. Hook strip
30. Dutch door
31. Floor drain
32. Compressor
33. Bulletin board, 26 x 24 inches
34. Waste paper receptacle
35. Sump



68—*Laundry for a 200-Bed General Hospital*

1. Metal washer, 24 x 36 inches
2. Metal washer, 42 x 54 inches
3. Soap tank, 90 gallons
4. Double compartment laundry trays
5. Starch cooker, 25 gallons
6. Extractor, 1—17 inches, 1-40 inches
7. Platform scale, flush with floor
8. Tumbler, 36 x 30 inches
9. Uniform rack
10. Ironing board
11. Utility press
12. Shakeout table with sloping sides
13. Flat work ironer, 4 roll, 120 inches
14. Table, 36 x 144 inches
15. Shelving
16. Marking machine
17. Tables, 1—30 x 60 inches, 1—30 x 48 inches, 1—36 x 72 inches
18. Shelf over table
19. Sorting bins
20. Counter, 36 inches high with shelving below
21. Sewing machine
22. Counter, 30 inches high with cabinets below
23. Wall cabinet
24. Filing cabinets below counter
25. Straight chair
26. Counter, 30 inches high, open below with drawer
27. Telephone outlet
28. Feed rack
29. Hook strip
30. Dutch door
31. Floor drain
32. Compressor
33. Bulletin board, 26 x 24 inches
34. Waste paper receptacle
35. Sump
36. Shelving with bins
37. Pass window
38. Gate
39. Water cooler

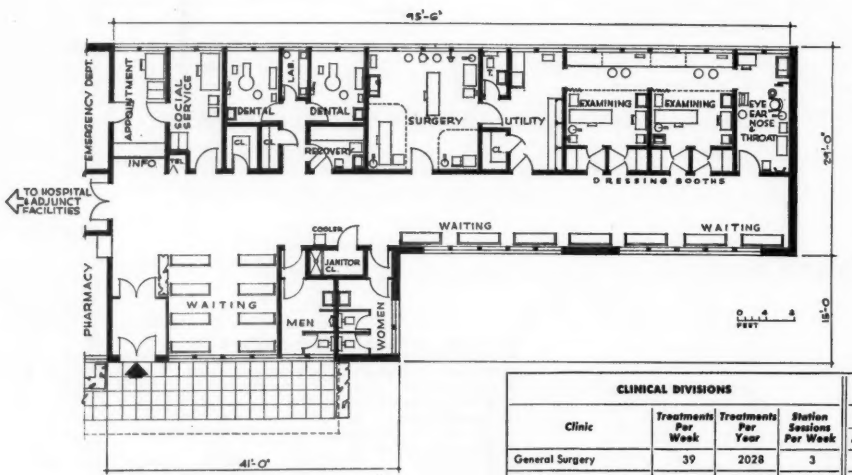
OUTPATIENT DEPARTMENT



69—Outpatient Department for a 50-Bed General Hospital

Possible Clinic Use Schedule—Based on Analysis of Clinic Load

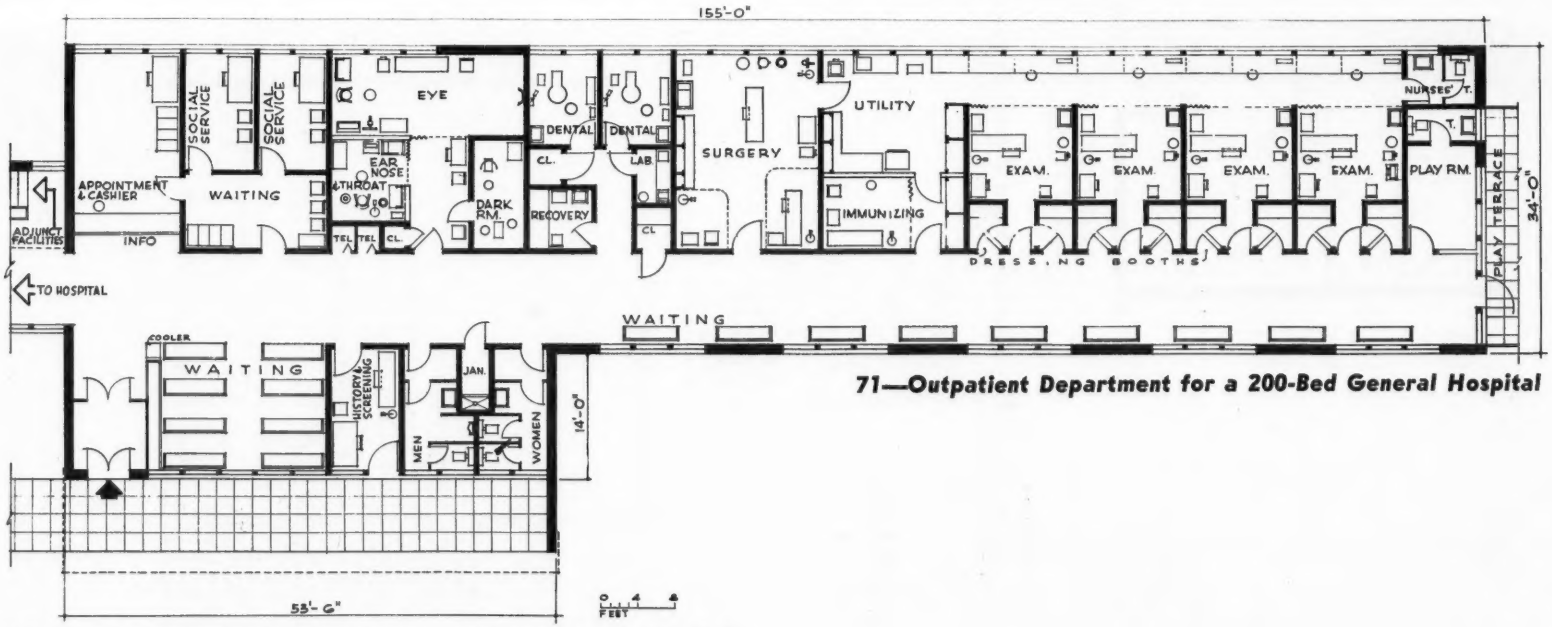
CLINICAL DIVISIONS				ASSIGNMENT OF STATIONS											
				Mon.		Tues.		Wed.		Thur.		Fri.		Sat.	
Clinic	Treatments Per Week	Treatments Per Year	Station Sessions Per Week	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
General Surgery	20	1040	2	1		1									
Proctology	1	52	1		1										
Urology	3	156													
Dental	14	728	2				1				1				
Gynecology	6	312	1					1							
Obstetric	5	260	1						1						
Orthopedic	7	364	1								1				
Eye	8	416	1									1			
Ear, Nose & Throat	10	520	1										1		
General Medicine	26	1352	3				1				1		1		
Neuro Psychology	3	156	1											1	
Pediatric	11	572	1									1			
Dermatology & Syphilology	8	416	1												1
Physical Therapy	3	156	1											1	
Totals	125	6500	17	1	1	1	2	1	1	2	1	2	2	2	1



70—Outpatient Department for a 100-Bed General Hospital

Possible Clinic Use Schedule—Based on Analysis of Clinic Load

CLINICAL DIVISIONS				ASSIGNMENT OF STATIONS											
				Mon.		Tues.		Wed.		Thur.		Fri.		Sat.	
Clinic	Treatments Per Week	Treatments Per Year	Station Sessions Per Week	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
General Surgery	39	2028	3		1				1		1				
Proctology	2	104	1	1											
Urology	6	312													
Dental	28	1456	3			1					1			1	
Gynecology	12	624	1	1											
Obstetric	10	520	1		1										
Orthopedic	14	728	1			1									
Eye	16	832	1				1								
Ear, Nose & Throat	19	988	2					1		1					
General Medicine	51	2652	5			1		1		1			1	1	
Neuro Psychology	5	260	1				1								
Pediatric	22	1144	3					1		1		1			
Dermatology & Syphilology	15	780	2									1			1
Physical Therapy	6	312	1											1	
Totals	245	12,740	25	2	2	3	2	2	2	2	3	1	2	3	1

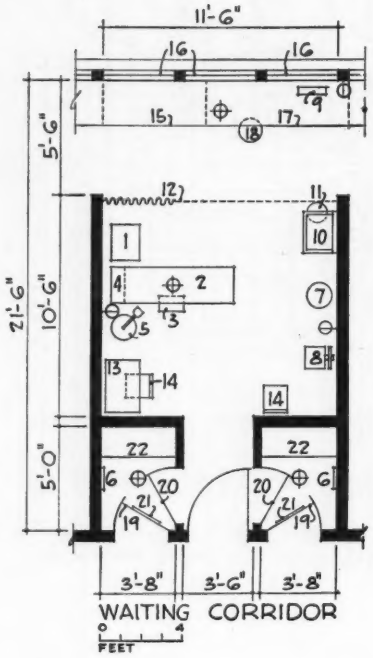


71—Outpatient Department for a 200-Bed General Hospital

Wall areas in Outpatient Departments should be provided for health education displays.

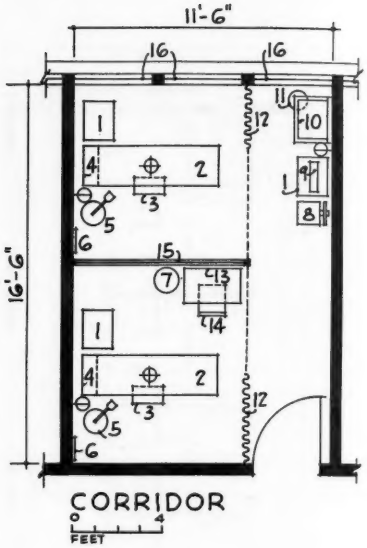
Possible Clinic Use Schedule—Based on Analysis of Clinic Load

CLINICAL DIVISIONS				ASSIGNMENT OF STATIONS											
Clinic	Treatments Per Week	Treatments Per Year	Station Sessions Per Week	Mon.		Tues.		Wed.		Thur.		Fri.		Sat.	
				AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
General Surgery	78	4056	6		1	1		1			1	1			1
Proctology	3	156	1		1										
Urology	11	572													
Dental	56	2912	6		2						2			2	
Gynecology	23	1196	2	1				1							
Obstetric	20	1040	2	1							1				
Orthopedic	28	1456	2			1									1
Eye	31	1612	2	1						1					
Ear, Nose & Throat	37	1924	3			1				1					1
General Medicine	102	5304	11	1		2		2		2		2		2	
Neuro Psychology	9	468	1							1					
Pediatric	43	2236	5		1						1	1		1	1
Dermatology & Syphilology	29	1508	3				1		1				1		
Physical Therapy	12	624	2	1											1
Totals	482	25,064	46	5	5	5	1	4	1	5	5	4	1	5	5



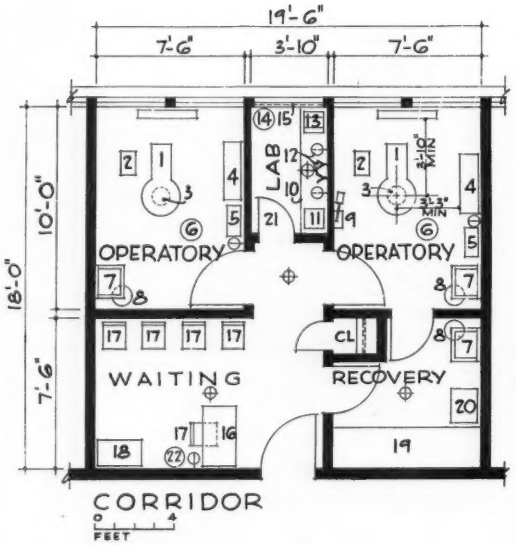
1. Table, 16 x 20 inches
2. Examining table
3. Footstool
4. Paper sheet dispenser
5. Examining light
6. Hook strip
7. Adjustable stool
8. Adult scale
9. Instrument sterilizer, 4 x 6 x 16 inches
10. Lavatory with gooseneck spout and knee or elbow control
11. Waste paper receptacle
12. Cubicle curtain and rod
13. Table 20 x 30 inches
14. Straight chair
15. Counter, 36 inches high with cabinets below
16. Obscure glass
17. Counter, 36 inches high, open below
18. Stool
19. Door, spring latch and with throw bolt on dressing room side
20. Door, spring latch
21. Mirror
22. Built in seat

72—Examination and Treatment Room with Dressing Cubicles



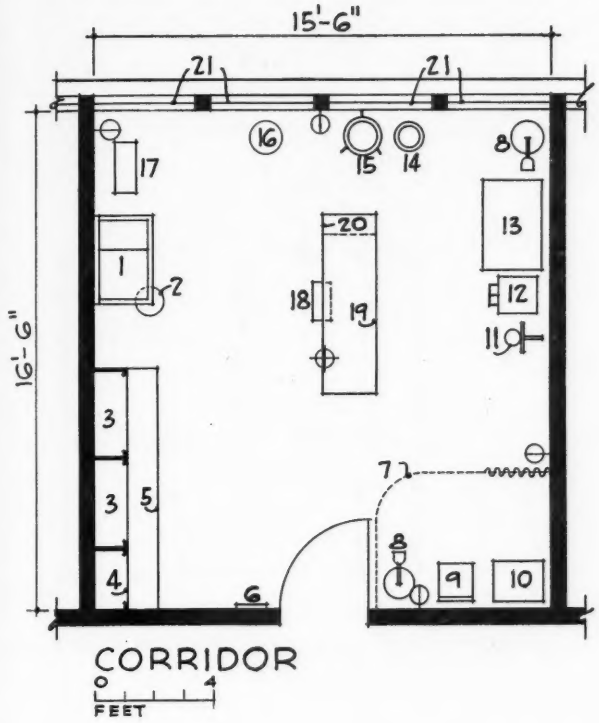
73—Examination and Treatment Room

1. Table, 16 x 20 inches
2. Examining table
3. Footstool
4. Paper sheet dispenser
5. Examining light
6. Hook strip
7. Adjustable stool
8. Adult scale
9. Instrument sterilizer, 4 x 6 x 16 inches
10. Lavatory with gooseneck spout and knee or elbow control
11. Waste paper receptacle
12. Cubicle curtain and rod
13. Table, 18 x 30 inches
14. Straight chair
15. Partition with obscure glass in upper panel
16. Obscure glass



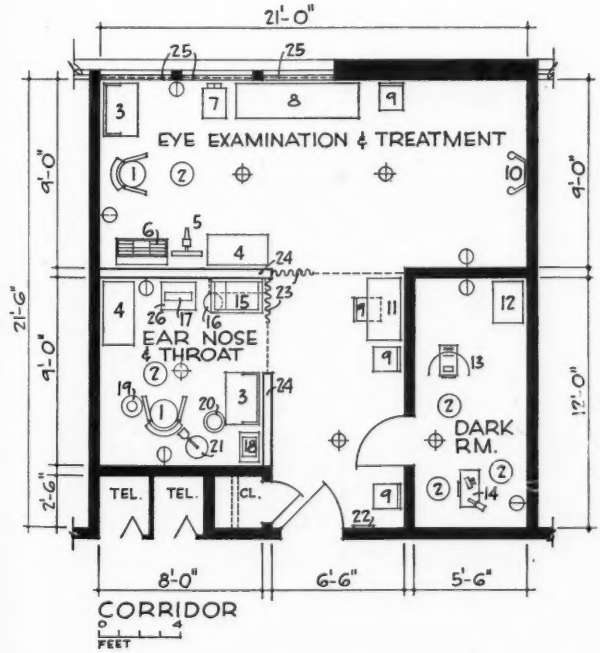
1. Dental chair
2. Dental unit
3. Dental operating light
4. Dental instrument cabinet
5. Instrument sterilizer, 4 x 6 x 16 inches, on stand
6. Adjustable stool
7. Lavatory with gooseneck spout and knee control
8. Towel receptacle
9. Dental x-ray, wall model
10. Laboratory counter, 36 inches high with cabinets below
11. Sink in counter
12. Gas, air and electric outlets
13. Developing tank
14. Compressor
15. Light proof shade
16. Desk, 20 x 36 inches
17. Straight chair
18. Filing cabinet
19. Built in couch
20. Bedside table, 16 x 20 inches
21. Light proof door with louvre
22. Waste paper receptacle

74—Dental Suite with Two Operating Rooms



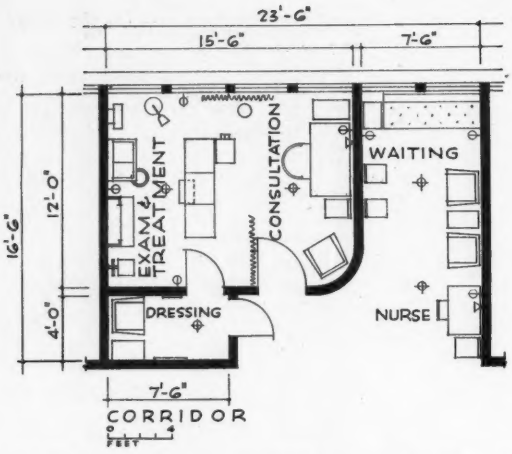
1. Combination instrument and scrub sink with gooseneck spout and spray and knee control
2. Waste paper receptacle
3. Wall cabinet
4. Locked wall cabinet with inner locked narcotic compartment and inside light
5. Counter, 36 inches high, with cabinets below
6. Hook strip
7. Cubicle curtain and rod
8. Examining light
9. Straight chair
10. Table
11. Irrigator stand
12. Mayo table
13. Instrument table
14. Sanitary waste receptacle
15. Kick bucket
16. Adjustable stool
17. Instrument sterilizer, 9 x 10 x 20 inches, on stand
18. Footstool
19. Examining table
20. Paper sheet dispenser
21. Obscure glass

75—Surgical Room

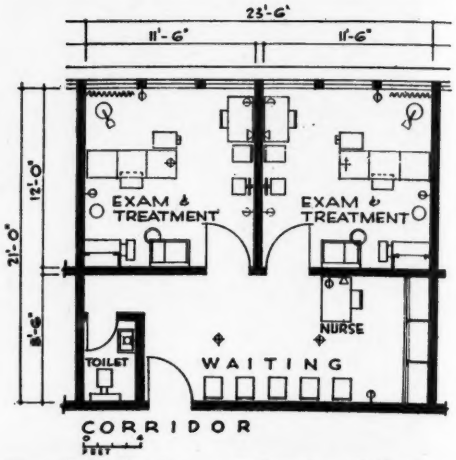


1. Specialist's chair
2. Adjustable stool
3. Treatment table
4. Supply cabinet
5. Examining spot light
6. Trial lens case
7. Mayo table
8. Examining table
9. Straight chair
10. Illuminated test card cabinet
11. Table, 20 x 36 inches
12. Table for transillumination equipment
13. Perimeter
14. Slit lamp
15. Combination instrument and scrub sink with gooseneck spout and knee control
16. Waste paper receptacle
17. Instrument sterilizer, 4 x 6 x 16 inches
18. Compressed air and vacuum apparatus
19. Fountain cuspidor
20. Sanitary waste receptacle
21. Examining light
22. Hook strip
23. Sliding curtain
24. Partition, 6 feet high
25. Shades or venetian blinds
26. Table, 16 x 20 inches

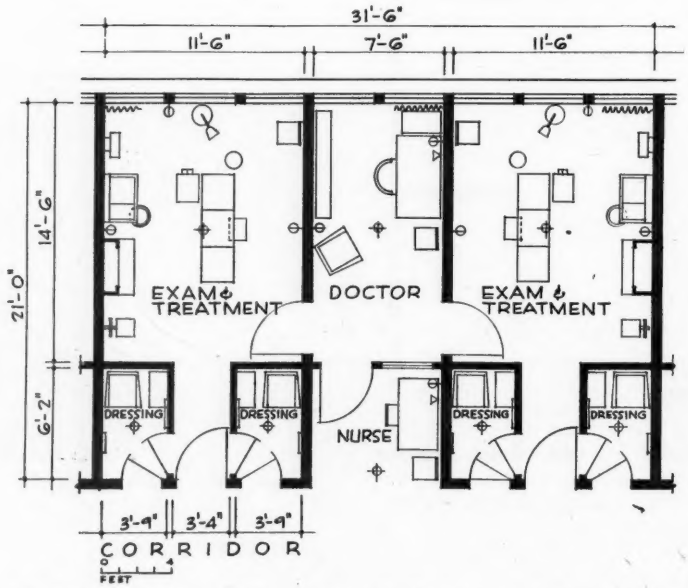
76—Eye, Ear, Nose and Throat Room for a 200-Bed Hospital



77—Combined Doctor's Office, Examination and Treatment Room with Waiting Room



78—Two Examination and Treatment Rooms with Waiting Room



79—Doctor's Office with Two Examination and Treatment Rooms

Three Guides to Finding a GOOD ARCHITECT

JAMES R. EDMUNDS JR.
PRESIDENT, AMERICAN INSTITUTE OF ARCHITECTS
AND
HENRY H. SAYLOR
EDITOR, JOURNAL OF AMERCIAN INSTITUTE OF ARCHITECTS

SELECTING AN ARCHITECT, whether for a hospital or for any other important building, is much like selecting a physician—the point is to get a good one. A good architect should possess three salient characteristics.

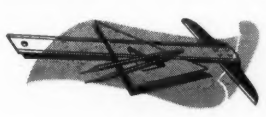
First, he should be a qualified designer. A designer should not be thought of as one who, familiar with the historic schools of ornament, resurrects them to embellish present-day construction. The term "designer" has no such meaning in the architectural profession. A designer in reality has the ability to put the right thing in the right place; to assemble and relate spaces for various needs so that the resulting building will function easily and pleasantly; to correlate the products of many different trades and skills so that these will best serve the purpose for which the building is required.

Design, in the architect's vocabulary, is aimed toward gaining stark efficiency and a plus quality. This plus quality is emotional appeal. A successful piece of architecture must work well and, in addition, be pleasant to live with. If the building should attain real beauty as well so much the better. The point to be emphasized is that the primary consideration in selecting an architect for a hospital is his ability to achieve efficient fitness to purpose rather than to produce a merely beautiful building.

The second qualification which characterizes a good hospital architect is technical knowledge. Obviously the architect's technical knowledge will include the elements of sound and sage construction. A man would never get past the examining board of his state if he did not possess that sort of technical knowledge. But he will need far more than that to create a good hospital. He should know how and where the doors of a hospital vary from those in a schoolhouse; how essential it is to prevent the occurrence of an electric spark in an operating room; how food is prepared and brought to the patient's bedside; how to introduce fresh air into a ward without creating a draft; how walls and floors should be finished in the interest of sanitation and low maintenance costs; how an isolation room may be made to isolate not only the patient, but his germs as well; how an x-ray department is made to dispense its rays beneficially and not harmfully.

There is no apparent end to this type of technical knowledge, particularly in view of varying opinions among administrators. Nevertheless, only in the sum of this technical knowledge is there assurance that the hospital to be built will function in accordance with the wishes of those who direct it and the needs of its medical staff.

Fortunately for the well-being of those for whom a hospital is built, all of this knowledge of special techniques is available to the architect who will seek it. Some architects prefer to make such knowledge their own by dint of personal study, travel and investigation. Other architects prefer to call in a consultant who specializes in this sort of knowledge as related to a special type of building. There are hospital consultants just as there are schoolhouse consultants, theater consultans, industrial consultants, and other specialists.



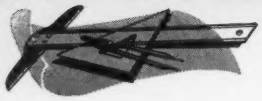
Frequently, if not invariably, a building committee will ask a potential choice the question, "Have you ever designed a hospital?" While the architect's ability to serve the hospital properly may be inferred from successfully completed work of a like character, an answer in the negative certainly does not mean that the architect is therefore incapable of designing a hospital. Many successful hospitals represent their designers' first efforts in that type of structure.

The third and final qualification essential to a good hospital architect may be labeled business ability. An architect's business ability is perhaps most easily checked by inquiry among his previous clients and among the contractors who have built for these clients under the architect's direction. In this general category of business relationships the architect's service governs many things.

He will see that the proper forms of contract are drawn; that the project is protected by suitable types of insurance; that payments are made when due and to whom due; that the subdivisions of the work by trades are properly channeled and correlated in time; that the owner gets what he is paying for; that necessary detail drawings get to the subcontractor or to the factory on a production schedule. In short the operation must be so orchestrated that the efforts of many men and the fitting together of many materials and pieces of equipment are brought to harmonious coalescence.

Even with an awareness of the preceding requirements, a hospital building committee must still solve the problem of actually finding an architect who possesses these basic qualifications.

The building committee charged with selecting an architect should thoroughly examine and try to evaluate past performances of the candidates with particular reference to efficiency of design, the prime prerequisite. If an architect has solved one or more fairly complex building problems however far removed in character from those presented



by a hospital, it seems reasonable to assume that solution of the latter is within his capabilities.

At the same time the committee should learn by questioning the owners and the operators of the plant or building under examination how well the structure has stood the wear and tear of usage and whether its maintenance and repair costs are reasonable. From this information an opinion of the architect's technical knowledge and judgment can be formed.

This sounds like a simple and easy procedure to an architect, but in practice it may not prove so to a lay building committee. If it were possible to obtain the advice and counsel of another architect who had no prejudicial interest whatever in the project in hand, the committee's work would be greatly facilitated.

Outlining a Program for Comprehensive REVIEW SERVICE ON PLANS

JAMES McNEE, FACHA
CHAIRMAN, COMMITTEE ON HOSPITAL PLANNING REVIEW SERVICE, COUNCIL ON HOSPITAL PLANNING AND PLANT OPERATION

ONE OF THE AREAS in which the comprehensive program of the Council on Hospital Planning and Plant Operation aims to provide a new service for Association membership revolves about a planning review service in connection with construction.

Many hospital administrators confronted with planning problems have often expressed the wish that there was some way they could seek the advice of other administrators. The administrators of many hospitals are able to do the basic research necessary and to outline for the architect the general arrangement of facilities they wish to have incorporated in their new building.

They often want, however, an opportunity to verify their judgment, which they may do by calling upon the advice of the administrators of nearby hospitals, or by referring their plans to a hospital consultant. There may readily be many instances in which the administrators may wish to employ both sources of advice to improve upon their original ideas.

Planning review service offers an opportunity for them to check their plans against multiple experiences of a group of administrators. Without an organized service of some kind, this kind of cooperation is difficult to achieve. Realizing the demands on his own time, the administrator is hesitant to encroach upon the available working hours of a colleague, unless he can do so on a basis which would compensate his fellow administrator.

Many hospitals, particularly smaller ones in areas more remote from metropolitan centers, are now without anyone to whom they can turn for hospital planning consultation. This situation develops from the fact that there are a limited number of administrators who engage in the work of hospital consultation, and the demands upon their time are such that they cannot extend their services to cover the total sphere of need.

Administrators who wish to augment the services of their consultant —those who require only the confirmation of opinions expressed from the standpoint of multiple experiences and those who find it impossible to secure a hospital consultant—undoubtedly will find value in the Hospital Planning Review Service now being planned by the council. Developments in the council's committee charged with investigating the possibilities of this service indicate a need, as well as a probability that a satisfactory program can be developed.

The pattern that the review service will probably follow was developed in the late 20s by the National Association of Building Owners and Managers. It calls for panels which will be composed of member hospital administrators and will be available only to review the final version of preliminary drawings for hospital construction.

In this function, the service cannot supersede the functions of the hospital consultant, since it will be unable to undertake any fact-finding activities nor can it take the place of the hospital consultant in making recommendations for original layouts, inclusion of various hospital facilities and their integration into a smoothly working structure.

The experience of the service provided by the National Association of Building Owners and Managers indicates that the review consultation is capable of effecting substantial savings by recommending various revisions to previously designed arrangements, by recommending the inclusion of facilities not previously provided for and by eliminating facilities which the composite opinion of the panel indicates to be inadvisable.

Because of the fact that general hospital annual operating costs are frequently in excess of one-third of the hospital's total valuation, rearrangement of facilities to affect operating economies mount substantially through the practical life of the hospital.

It is contemplated that each review service panel will include one or more administrators from the general geographic area in which the proposed structure is to be built. When, among its other functions, the panel reviews proposed rates of charges and operating costs,

this local knowledge and experience becomes a valuable factor in determining whether the hospital's economic arrangements have been made on a realistic basis.

The committee is in general agreement on the principle that this type of service can be established on a practicable basis only if satisfactory compensation is made to panel members for the time they devote and, further, that the service should be provided through Association facilities on a basis that will keep it self-supporting. Accordingly, the committee plans to work out a system of compensation and charges for consideration of the various Association bodies that will be called upon to study the program before it becomes effective.

The current thinking of the committee is that this service should be offered only to members of the Association. This restriction, however, need not deprive communities considering the establishment of a new hospital organization of an opportunity to participate in this service. The Association accepts such hospital organizations as associate institutional members until their hospital has been erected and in operation long enough to meet the qualifications for active institutional membership.

The committee plans to recommend that a roster of potential panel members be compiled. Personal members of the Association or the voting representatives of active institutional members—who are actively engaged in hospital administration, in supervisory capacities for groups of hospitals or in special capacities for governmental or similar health agencies—will be eligible for inclusion in this roster, providing their experience in hospital administration and construction meets certain minimum standards yet to be developed.

Panels for the review service are to be chosen from among the members of this roster by the subscriber hospital. The subscriber hospital will also be responsible for the furnishing to the panel of the substantial amount of data needed in order that the prospective plans may be properly analyzed. In its deliberations, the panel will be joined by members of the subscriber hospital's board of trustees, their administrator, their architect, their hospital consultant, if any, and whatever other hospital personnel the subscriber elects.

These general ideas digest the current conclusions of the committee. All of these recommendations are still open to debate and amendment. More basically, decisive action is yet to be taken on the very establishment of the service. However, the indications are that the service would provide a definite answer to an unsolved problem and that it is unlikely to overlap to any extent the functions of the consultant. There is good evidence to substantiate the basic premise that this service can save the Association's member hospitals many building dollars and many more operating dollars and thereby thoroughly justify its establishment.

Public Relations Turns to HEALTH EDUCATION

AT MOUNT SINAI HOSPITAL in Chicago, the initial four monthly health educational meetings have been well attended. Described as a public relations project, the program is designed to acquaint the public and the hospital family with ways of achieving and keeping good health. In doing that the program has been successful in its early days.

That the meetings will increase in popularity and become an integral part of the hospital program is hoped for by the promoter, Mrs. M. D. Newfield, superintendent of volunteers at the hospital, and by Dr. Stephen Manheimer, hospital director.

Originating in a department head meeting, the idea has developed into a planned program. A four member committee was named from the department head list and this group is responsible for outlining the general patterns of programs. When a topic is named, the hospital department whose work routine is most closely related is named host for the evening's event.

Each session is opened with a short movie, the films being obtained from public health agencies. The guest authority is then allowed half an hour for his talk. These talks are non-technical presentations designed primarily to benefit the lay volunteer workers and hospital friends. Outsiders have constituted more than half of the near 150 persons attending each month.

Cards are distributed at the opening of each meeting for submitting questions and suggesting topics for future meetings. Because of the spontaneous verbal response, these cards have not been used extensively. They are of greatest value for those who might not voice a question because of personal factors and it is often those questions which determine the usefulness of the program to an attending individual.

Posting illustrative placards and distributing educational leaflets in the lecture hall helps in presenting the topic. Like the films, these are obtained from health service groups.

A short visiting period, during which time a small lunch is served, concludes each program.

It is planned to continue the health program for nine months of each year. If open meetings are conducted during the summer, they will be for recreation only.

In the first four meetings the topics discussed were nutrition, with Margaret Falstand, associate director of the department of nutrition of the American Red Cross, as guest authority; sleep and relaxation, Dr. Nathaniel Kleitman, professor of physiology of the University of Chicago; cancer, Dr. J. J. Moore, pathologist and former president of the Chicago Medical society, and Blue Cross. How to live comfortably in summer will be discussed at the May meeting.

Increasing enthusiasm has been shown toward the program. At Mount Sinai the small Kurtzon auditorium can accommodate only 150 persons. A new nurses' home is near completion and by autumn it is hoped that this will permit attendance by almost 500 persons.

Attaining Economy in the Pharmacy Through NON-STERILE MANUFACTURE

ROBERT A. KUMPF
CHIEF PHARMACIST, NEW HAVEN UNIT, GRACE-NEW HAVEN COMMUNITY HOSPITAL

MOST HOSPITALS, regardless of size, can effect considerable dollar savings by manufacturing in the pharmacy department. The term manufacturing includes both sterile and non-sterile products, but the discussion here will be regarding preparations of a non-sterile nature, since another article in his series will cover sterile solutions. This paper is concerned chiefly with the manufacture in bulk quantities of standard formulas for inpatient and outpatient consumption on an "ahead of time" basis.

A list of products that can be manufactured includes everything from simple solutions to tablets of every size and description, and could include capsules, tinctures, elixirs, mixtures, massage alcohol, lotions, suppositories, syrups and ointments. All preparations used in the hospital which are official in the United States Pharmacopoeia and the National Formulary as well as special formulas of a like nature which have found a place in the hospital medicinal formulary should be included.

The list may include many formulas for special investigational use and such items as complex vitamin preparations. Aside from medicinal substances, the department may prepare such items as deodorants, duplicating fluid, floor waxes, metal polish and other products normally required by a hospital.

There are definite advantages to manufacturing in the pharmacy, but the chief one is dollar savings. For the products the pharmacist is able to make, it can be shown that many costs can at least be cut in half, others more or less. We believe that the minimum saving that can be effected is not less than $2,000 annually for each 100 beds. Thus, a 500 bed institution can save approximately $10,000 a year. These figures will fluctuate somewhat according to the presence or absence of a dispensary clinic since consumption of drugs by clinics is considerable.

We consider it good judgment to make many products in the interest of consistency, since there are frequently variations in products obtainable commercially unless all are purchased directly from one manufacturer. Lack of consistency requires time-consuming explanations to nurses, doctors and patients, often with uncertain and dubious results.

Manufacturing is also an advantage because of lack of immediate availability of finished products in local markets, even though a marked monetary savings may not be effected. Raw materials are nearly always available on the pharmacy shelves for ordinary prescription compounding and an increase of bulk material and the number of items will permit their use for manufacturing.

Quality will be equal with that of products obtainable commercially. Pharmacists are well trained in the art of compounding all pharmaceuticals having an official status as previously mentioned. A great percentage of the medicinal substances required for hospital use fall within this category, or are simply prescription formulas adopted by committees responsible for the hospital medicinal formulary. None of these involves a professional art beyond the reach of the experienced hospital pharmacist and the quality should be beyond reproach.

The equipment required to proceed with the plan outlined here need not involve too much of an investment. For a hospital of 150 to 200 beds, existing technical equipment used for prescription compounding, plus a small suppository machine, portable mixer and glass lined storage tanks for soap, germicides, medicated alcohol, and similar items may suffice. The investment will not be over a few hundred dollars. In some smaller hospitals much can be done with little more than ordinary prescription necessities.

In larger institutions of 500 bed capacity, it can be shown to be good economy to manufacture compressed tablets. A single punch tablet machine along with equipment for powder mixing and granulating —all or part of which may be essential—require a total investment of about $1,000. Likewise an ointment mill, a batch mixer of 20 gallons or more capacity and filtering equipment, may well find a place in these institutions with possibly a few hundred dollars more invested.

These figures may sound like considerable money to some readers, but in a year or so (and more often less than a year) the money will be returned with interest. And "interest" will come in a different way also—in inspiration and accomplishment. Following is a list of suggested equipment, all or part of which may be needed to adapt the plan to your hospital:

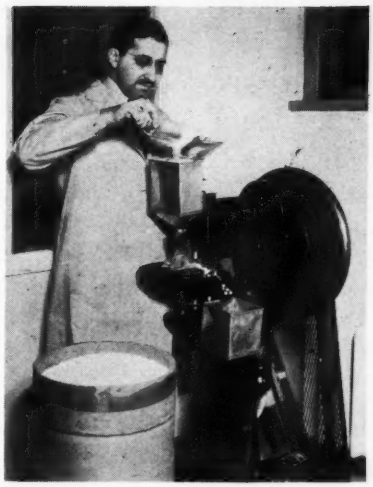
Water	Viscolizer
Batch mixer	Filter transfer pump
Storage tanks (glass lined)	Suppository machine (cold)
Portable mixer	Suppository molds
Ointment mill	Hot plate
Tablet compressing machine	Water bath
Powder mixer	Tube filling machine
Wet and/or dry granulator	

This list does not include ordinary small technical equipment required for prescription compounding, since all hospitals operating a pharmacy already have these. Others are already doing manufacturing on a limited but outmoded scale, but may have part of the items listed, such as a water still. Very large hospitals may find this list inadequate and some of the equipment may be obsolete for very expanded programs. The group mentioned here, however, should fill most of the needs for the average institution up to 1500 beds.

In establishing an efficient and progressive manufacturing laboratory, regardless of size, it is advisable to make available a number of text books covering the subject needs, as well as current magazines to keep the pharmacist posted on markets and special formulas. The dollar investment is not large. It is well for the manufacturing pharmacist to develop a formulary of his own with complete details as to procedures on bulk formulas.

The following list of suggested books and periodicals, (although many others are available and may seem more adaptable) will serve as a guide for the uninitiated: *Professional Pharmacist, Drug & Cosmetic Industry, Journal American Pharmaceutical Association* (practical edition), *Drug and Cosmetic Industry Journal*, "Art of Compounding" (Scoville), "Tablet Manufacture" (Stokes Machinery Co.), American Pharmaceutical Association recipe book.

In expanding pharmacy facilities to permit the execution of any manufacturing project, it will be necessary to consider floor and shelf area requirements. The trend of hospital architects in the past few years has been to allocate approximately five square feet of floor area per bed to the pharmacy department. Approximately 25 per cent of this area should be allotted to manufacturing and 50 per cent to storage. Arrangement and subsequent division of the space will depend on the extent of manufacturing and the efficiency of the storage area. Here much consideration should be given to shelving. At least two square feet of shelf space is necessary to properly locate all raw materials and finished products in the manufacturing unit.



MANY TYPES of tablets used in quantities can be manufactured at considerable savings.

In considering the requirements in relation to their particular problem, many administrators will find that many of the requirements already have been met, or can be met with a little rearrangement of existing equipment.

In order to manufacture on any scale, it is, of course, essential that the hospital employ a competent pharmacist, unless such a person is already available full time. Often with proper organization of procedures, the existing personnel has less active periods which may be devoted for all the manufacturing that it is practical and profitable to do. In hospitals normally employing more than one pharmacist, part time of one or both may be allocated to the project. In hospitals of 500 beds or more it can be shown that it is profitable to employ a pharmacist—and possibly one or more assistants—specifically for the manufacturing unit.

Before entering into any manufacturing in the hospital pharmacy, it might be wise to prove the soundness of the venture. It is important to remember the points previously discussed in this article regarding quality of self made products, convenience of extemporaneous preparation and consistency in products, but all of these are of secondary importance until it can be shown that actual dollar savings are effected.

A survey of the problem might be made reviewing all purchase of tablets, ointments, suppositories and pharmaceutical preparations for the last two years. Determine the cost of purchasing these on a contract basis for a year; consider their costs and the total cost of manufacturing these products yourself. In finally determining the savings you can effect, consider chiefly the out-of-pocket costs for any investment necessary to carry out the program. This cost may entail some extra expense. On the other hand you may require only existing labor, space, power and equipment and it may not be fair to include these in computing the actual cost of manufacturing.

For establishing a complete manufacturing laboratory all these items must, of course, be included, along with general hospital administrative costs and amortization of any equipment installed for the purpose.

In determining savings, a breakdown for each type of product is also advisable. For example, the problem of tablet manufacture involves a recapitulation of all the tablets which it is practical to manufacture, with particular consideration given to the savings possible, maintenance and amortization of tablet machinery required. Likewise, in making bulk quantities of ointments, it may not be proper or wise to invest in machinery unless the total requirements will produce ample savings to pay for it.

SUMMARY

In summarizing, it may be pointed out that manufacturing of nonsterile products in the hospital pharmacy has definite advantages—chiefly, dollar savings. Other important advantages are quality, consistency and greater availability, as well as improvement in service and reduced cost to the patient. It has been shown that the plan involves a relatively modest financial investment and may provide for more productive use of available pharmacy personnel.

Editorials

Welcome!

ALL VETERANS ADMINISTRATION HOSPITALS, now numbering 100, have become members of the American Hospital Association. In extending a special welcome, we recognize the coming of these new members as an event of importance.

This is the first time federal hospitals have been permitted to hold membership in any association, and much can be made of the precedent.

It used to be that federal government hospitals and voluntary hospitals had little in common, but that day is fading fast. In the age we are now entering, health care is widely viewed as a national problem. Whatever the fate of pending legislation, we may never again expect to see the broad field of health care divided into several strictly autonomous areas. The areas must continue to exist for practical reasons, but there will be much more collaboration across the borders. There appears to be no other procedure, if we are to maintain our high American standards, at the same time adapting them to new demands.

Association membership on the part of Veterans Administration hospitals can be merely a symbol of this new collaboration, or it can be considerably more if some effort is expended on both sides.

Every veterans' hospital may nominate a representative to participate in Association affairs. Eighteen state associations affiliated with the American Hospital Association have extended full membership privileges to these representatives. Such is the foundation for a new relationship that should be mutually profitable. The Association offers all its services and facilities—its literature, its Bacon Library, its meetings, its many special programs.

Hospital Construction

THE IMMEDIATE OUTLOOK for hospital construction is something less than cheering, as anyone who reads this issue of HOSPITALS must realize. A shortage of labor and materials was more or less anticipated, but the rise in costs is much beyond the expectations of most administrators and trustees.

If costs climb to $8,800 a bed, the mean-figure estimate of several architects, the building plans of many hospitals will be seriously affected. There will have to be a choice between less plant for the budget already fixed, and a further postponement while more funds are raised. In either case a great deal of planning effort will have been wasted.

While this waste and confusion are in no sense welcome, an unavoidable wait for materials or labor or more building money may be turned to advantage in many cases. For one thing, the administrator without a good deal of building experience today may draw upon three resources that were never before available—all of them new services of the American Hospital Association.

These are a roster of approved hospital architects, a list (not officially approved) of experienced hospital consultants, and a planning review service that is described in this issue of the journal. From this time forward, no hospital need be inadequately planned or poorly build for lack of expert guidance.

In addition, the war has left many communities with changed or changing requirements for hospital facilities. The war has combined with other factors to set in motion some trends that affect hospital requirements everywhere. There is a trend toward greater volume of hospital care of all kinds, a trend toward greater government concern with the availability of hospital care, a trend toward extending the scope of a general hospital—to mention only a few.

The pressure for more and better facilities is such that no hospital is likely to await developments, if it is in a position to proceed with construction now. At the same time, the prospect is not quite black for those who must overhaul their plans.

Reminder

PUBLIC RELATIONS as an art or science has grown in many directions since the inauguration of National Hospital Day, but nothing has quite taken the place of this early device for periodically reminding the community of its hospital needs and achievements.

Every year on May 12 there is a job to be done in every community, this year perhaps more than ever. Nearly all hospitals are still struggling to maintain service under the handicap of war-born shortages. A good Hospital Day program can attack this problem in two ways. It can call attention to the need for help, and it can explain without apology the difficulties under which service is maintained.

The voluntary hospital as an institution continues to be threatened with extinction by well-meant proposals for reform. These threats will vanish when a greater proportion of the public appreciates the value of its voluntary hospitals; and to spread such apreciation is the primary purpose of National Hospital Day programs.

Service Benefits

BLUE CROSS PLAN EXECUTIVES, meeting in Cincinnati late in March, petitioned the Board of Trustees of the American Hospital Association to issue an unqualified endorsement of service benefits for Blue Cross subscribers. It was a timely and significant action.

The dramatic growth of this voluntary movement for making hospital care more readily available has fired the imagination of the American people. No other cooperative movement has ever enlisted in so short a time the support of some twenty-one million people. It is an outstanding example of the public organizing to meet its own needs, rather than transferring that responsibility to government—as has been suggested as the easy solution to many social problems.

But the remarkable growth of Blue Cross also has created a great new problem, one that is made more acute by the nature of these times.

Hospitals today are confronted with sharply rising costs. Through the phenomenal expansion of Blue Cross, a steadily increasing proportion of hospital facilities are used by Blue Cross patients. With their service contracts, these patients offer no ready source of new income with which to meet the new costs.

As a first alternative, the administrator naturally turns to the hospital's non-Blue-Cross patients, those who may be asked to pay the increased cost of each service used. The extent to which these separate service charges may be raised is obviously limited, and now it develops that the number of patients subject to such charges is steadily shrinking.

Facing this obstacle, the administrator is bound to weigh a second alternative. If the hospital might charge *all* patients for each separate service according to cost, it would be fairly easy to get revenue and expenses back in balance.

Service benefits? The administrator may be no less imbued with the ideal, but somehow he must make ends meet; and he finds little comfort in the prospect of waiting for the tumult of reconstruction to wear itself out. Still it is plain to anyone who looks into the future that this second alternative will not do—that service benefits cannot be abandoned without jeopardizing the entire voluntary movement.

If the solution lies not in abandoning service benefits, neither does it lie wholly in retaining them. The immediate future requires that hospitals reaffirm their faith in the principle that Blue Cross subscribers receive full service. It also requires Blue Cross plans to see that hospitals receive adequate payment for the services used by Blue Cross patients.

A joint meeting of the Hospital Service Plan Commission and the Board of Trustees is scheduled for June 28. Between now and June 28 there is time enough for all concerned to familiarize themselves with the whole issue. If this is done, the great new problem will be solved, as were some equally great problems that arose before the war.

An Urgent Invitation

THE PLAN to make medical and hospital care available to veterans with service disabilities, in their home communities, has suffered some delay that probably is unavoidable under the circumstances. It has been necessary for many thousands of people scattered through hundreds of communities to grasp a wholly new idea of cooperation between federal government and voluntary agencies.

Up to this point the delay has not been a serious threat, but it can easily become one. The Veterans Administration stands ready to deal with every hospital in the United States, as nearly as possible on the individual hospital's own terms. No one is asked to provide care for veterans at less than actual cost, and never before has so large a government program been reduced to such a minimum of red tape.

But at the other end of the equation there is a variety of voluntary organizations—hospitals, hospital associations, Blue Cross plans, state and local medical societies. They represent a cross-section of the voluntary movement, and as such they are confronted with the most dramatic challenge ever extended to this movement.

Each agency directly involved has a full backlog of immediate problems. Each feels obliged to guard its own prestige against all encroachment. Each is tempted to pass by any involvement that might disturb a comfortable atmosphere. If even a strong minority of the organizations directly exposed to this challenge follow such inclinations, the test case will be lost.

In a majority of the 48 states, no progress is reported by the Veterans Administration. In all areas, but especially in these, there is an obvious need for leadership; and in the end it makes little difference who or what organization takes the initiative. The steps leading to necessary contracts with the Veterans Administration are reported in the news section of this issue. To start negotiations or to speed them along—here is an open and urgent invitation to hospitals.

Local Control

SINCE THE DAY after Japan's defeat the Association has kept in touch with federal agencies concerned with the control of building materials. Although the Civilian Production Administration's order of March 26 gives no special recognition to hospital needs, the resulting situation could scarcely be more promising.

Requests for construction permits will be passed upon by regional advisory committees made up of local citizens. Assuming that neither the law nor current administrative intent is changed, individual hospitals should have little trouble these days proving that construction is essential.

July Institute Will Study
COST ANALYSIS

IN LINE WITH current interest in the field of hospital accounting and business management, the American Hospital Association announces an Institute on the Theory and Practice of Cost Analysis in Hospitals to be held at Indiana University, Bloomington, July 22 through 26. Stanley Pressler, C.P.A., associate professor of accounting at the university, and consultant to the Association's Accounting Committee, will direct the five day institute. Capable and experienced men in the field will comprise the faculty.

The first days of the institute will be devoted to lectures and discussions pertaining to basic theories of cost principles, objectives of allocating costs and the mechanics involved. Beginning on the second day a specific problem will be analyzed and subsequently worked out according to three methods long favored in the field.

The three will be explained in step-by-step procedure as each applies to a 200 to 300 bed hospital. The second and third methods will be described in detail on the third and fourth days. On the last day results will be studied, contrasted and discussed in terms of rate application.

On Tuesday and Wednesday nights a group discussion, led by one of the faculty members, will take place. Remaining members of the faculty will be available for meetings and conferences involving individual problems. On Thursday night several groups will be formed —each to study one of the special problems of nurse education cost, group payment plans, x-ray department costs, and comparable nursing costs on medical and surgical floors.

INSTITUTE IN TEXAS

Plans are being scheduled for a five-day Institute on Basic Accounting and Business Procedures to be held in Houston, Texas, beginning June 9. An extensive program is being drafted jointly by the Association and a local committee, with enrollment expected to be limited to 100 persons.

Requests for information regarding requirements, application forms and other details should be addressed to: Kenneth Williamson, secretary, Council on Administrative Practice, American Hospital Association, 18 East Division Street, Chicago 10.

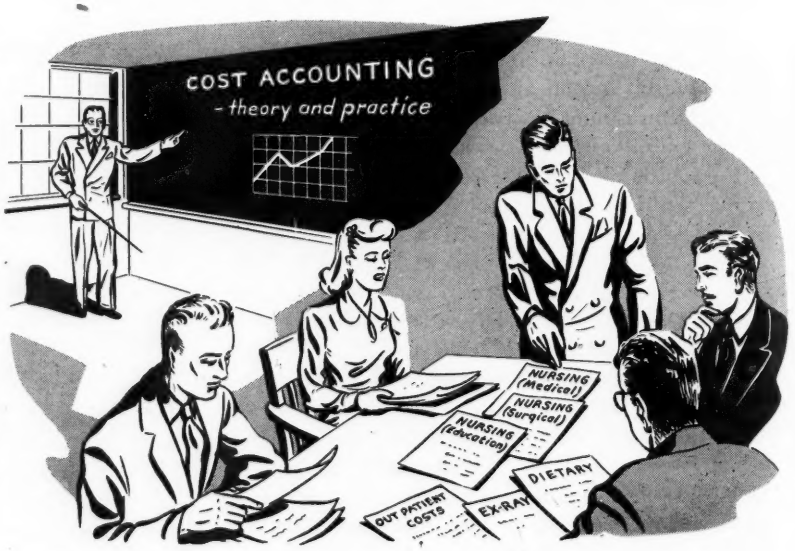
In view of the importance of both the subject and plan of study to be followed, attendance will be limited to a maximum of 75 registrants meeting the following requirements:

"Registrants will be limited to persons who are members of the American Hospital Association, or employed by hospitals which are institutional members, and who are employed in hospitals of 100 or more beds.

"Applicants must have had two years of accounting work at the university level, or the equivalent in experience, which is to be determined as three years work in a supervisory capacity in hospital accounting and business management."

The institute fee has been fixed at $20. Room cost and meals at the university for the five day period have been set at $25. As an unusual amount of interest is anticipated, those who are eligible and wish to attend are advised to send for an application form at an early date. Requests should be addressed to: Kenneth Williamson, Secretary, Council on Administrative Practice, American Hospital Association, 18 East Division Street, Chicago 10.

The application should be completed in detail and returned to Mr. Williamson accompanied by a check for $20 covering the institute fee. The fee for room and meals is payable at the university at the time of the institute.



EMPHASIS will be put on the practical techniques of accounting for hospital departments.

GOOD personnel-management relations are maintained by encouraging employees to contribute ideas for improving the firm's operations.

EMPLOYEES SHARE *Responsibility* *By* MULTIPLE MANAGEMENT

THOMAS R. REID
DIRECTOR, PERSONNEL AND PUBLIC RELATIONS, McCORMICK & COMPANY, BALTIMORE

ANY BUSINESS ORGANIZATION can improve its management-employee relationships by taking a lesson from the American government. For centuries wars have been fought to keep free the American democracy, which gives every citizen the right to a voice in how the country is managed.

Yet the average employee in American business has less participation in the management of the company than in democratic government.

There is a practical way to achieve this feeling of participation in the affairs of the company which will help to improve employee morale and at the same time produce many ideas for the good of the business. Whether that business happens to be a hospital or a manufacturing plant makes little difference fundamentally.

The plan can be applied to any hospital; the pattern is flexible. The basic philosophy is to bring more people into management of the enterprise.

It is called multiple management. Multiple management trains leaders, produces ideas and wins the confidence of the employee group by showing that management holds a sincere interest in employee welfare.

Developed in 1932 by Charles P. McCormick at McCormick & Company, Baltimore food and drug products manufacturing firm, the system has succeeded in that business and 500 other firms in the United States and abroad which have put the plan—or some variations of it—into effect. Multiple management is adaptable to any size and type of business; it has succeeded in manufacturing plants, banks, retail and wholesale mercantile companies and church organizations. The system will also work in hospitals.

Multiple management has passed both the preliminary research and laboratory experiment stages. The plan is a veteran of 13 years' operation and the years since 1932 have been an excellent testing period. In that time the business has gone through the lean years of depression, the testing times of returning prosperity and a great world war.

In tribute to the soundness of the original principle, the plan has survived all these varied cycles of business circumstances. Each new test has proved that multiple management has the strength to meet any situation which might arise. There are frequently expressed beliefs in the company today that with multiple management the path has been easier through depression and war than through normal periods without it. Its flexibility has been demonstrated the hard way.

This article describes the company's experiences under multiple management. As a member and former chairman of the junior board of directors, I can present the viewpoint of one who is intimately associated with all details of multiple management and has benefited by its philosophy.

The fundamental is a simple one easily applicable to any business operation. The plan's name means exactly what it says—"management by many." Its basic premise is that the more persons who can be

brought efficiently into active management participation, the greater will be the employee's knowledge and interest in company affairs.

McCormick & Company has four boards of company directors rather than one. It has 50 directors rather than the normal 12 or 15. Furthermore, all of these are active directors—company executives whose interest in McCormick is their main interest. They are not absentee directors. The system assures representation on its management boards of every one of the 920 employees—just as Congress assures representation in its two houses for every one of the nation's 130,000,000 citizens.

This, in brief, is multiple management. It is the opposite extreme to the old school of business management which held that control by one man at the top, or at most a few men at the top, was the right way to get a job done fast and well.

Multiple management is the sort of thinking in business which is comparable to democracy in government. I came to McCormick & Company because of multiple management, following years of service as executive vice-president of the United States Junior Chamber of Commerce, an organization of 125,000 young businessmen between the ages of 21 and 35. It was my job to observe the opportunities for young men and to determine how they could serve best the free enterprise system.

The first step toward bringing more men into management was the establishment of a second board of directors in 1932. There already existed the usual policy group which up to that time had for the large part merely endorsed the president's course. This board was renamed the senior board of directors and made active as a real policy-determining body working with the president. Then, Mr. McCormick organized a new junior board of directors. This second board was made up of all executive-minded men in the company, young or old, who were not members of the senior board. They were given power to govern themselves. They set up their own bylaws and elected their own chairman and secretary. They were told to set up in the bylaws a procedure to perpetuate their board with semi-annual elections so they would, after the first group, regularly drop three men who proved least capable and give three new men in the company a chance to prove themselves.

The factory board of directors was a logical next step. This board was set up to include as members those men who were not on the senior or junior boards but who were primarily concerned with manufacturing and production problems. This group set up its own bylaws and procedures identical with the junior board and elects its membership semi-annually.

Soon afterward the third development came with the establishment of the sales board of directors. Here the membership was chosen from sales executives working in Baltimore and salesmen throughout the country, who had demonstrated special abilities and interest in the company's good, to qualify them as representatives of the sales force. This board meets less frequently because its members are located far from the home office in most cases. The board meets at sales conventions and conferences at least once or twice a year and it is felt that the management contributions of outside men working and studying field conditions is a valuable aid to round out multiple management.

The principle still applies that the junior, factory and sales boards act as "feeders" of ideas to the senior board. For our business, the three lower boards cover the logical three branches of the firm—office, factory and sales. The junior board has now assumed practical responsibility for policy consideration on such matters as: Merchandising, sales campaigns, advertising, office efficiency, office personnel, new products, packaging and packing, market surveys, public relations and executive training.

The factory board considers and advances ideas on such matters as: Production schedules, new machinery, building maintenance, factory personnel, machinery improvement, time and motion studies, shipping problems, warehouse policies, stock handling, order filling, safety and first aid and foremen training.

The sales board confines itself exclusively to merchandising, sales and advertising matters.

It is important to note two things in reference to this division of functions which, incidentally, have never been set but which have proved to be the logical division of subject matter for consideration as shown by a study of the minutes of meetings for the boards over a period of years.

1. There is no attempt by the senior board to define the limits of junior or factory board discussion.

JUNIOR BOARD members prepare for executive jobs by considering practical office policies.

It is considered essential that members have a place to express their beliefs on any phase of the business. Senior board members are invited but seldom sit in on junior or factory board meetings. Opinions are stated freely and discussed on any matter of interest. Thus, members whose normal duties might be concerned with one small department of the business, are given training and knowledge of all functions of the business and gain a much broader concept of company affairs.

2. Board discussions and decisions are not final. This answers the question often asked us: "What keeps these young fellows from taking the business into their own hands?" The junior board and factory board discussions can be enacted into recommendations on any topic only by unanimous vote of board members. This means that the "radical" is counterbalanced by conservatives and vice versa.

A junior or factory board recommendation is then referred to the senior board (or, on minor matters to senior board members who head the department concerned) for final action before being put into effect as a company policy or operation. Ideas are discussed so thoroughly before being enacted as recommendations that the record of acceptances by the senior board is amazing.

A study of junior board minutes over a five-year period reveals that 2,109 definite recommendations were passed and submitted to the company for action. Of this number, only six were turned down; thus 2,103 fresh new ideas found their way into company operations. This represents a greater number of ideas put into effect than the board of directors had enacted under the old system in the entire period from 1889 to 1932.

It is not the purpose of multiple management to cut across departmental lines or assume supervisory authority. The boards must be looked upon as supplemental idea groups, discussion groups and training schools for executives—and not as deciding factors on every routine decision. Department heads and supervisors have the same functions and the same kind of authority to plan and act for the good of the business as those of any other company—and act with the same efficiency. But the multiple management boards help them by encouraging ideas, reviewing and discussing plans and preparing men under top management for vacancies as department heads as they occur.

MR. REID

The training school function of multiple management has proved over the years to be almost as valuable to the business as the idea-originating function. The senior board of the company now consists of 12 men in addition to the president. Of those 12, eight are former junior board members. The young executive who was chairman of the junior board in 1933 is now a vice-president of the company at the age of 36.

Similar evidence of training in executive leadership through the junior and factory board are reflected in choice of supervisors and foremen. Every foremen of consequence in the plant today has served on the factory board and many on the junior board. Except for department heads in the office who were on the senior board in 1932, every department head in the company today is a former junior board member.

In 10 years, 57 young executives were given opportunities to prove their ability on the junior board, under the system which calls for replacing three active members each six months with three new members. There have been 64 men given similar opportunity to serve on the factory board in the same period.

The sales board has given the executive group in Baltimore three men to serve in critical inside capacities since the war began.

Multiple management trains men to manage. When executive vacancies occur, there is a man ready to step in who knows the company as a whole—not one department only—and who has had practical experience on the junior, factory or sales board in leadership and executive procedure.

Multiple management was equal to the test. This business was converted from 100 per cent peacetime operation to more than 45 per cent war business with new products in a few months.

None of the gains in employee welfare and good relations were lost in the transition. Good employee relations and multiple management training systems were a salvation in days of high turnover, abstenteeism and draft demands on manpower.

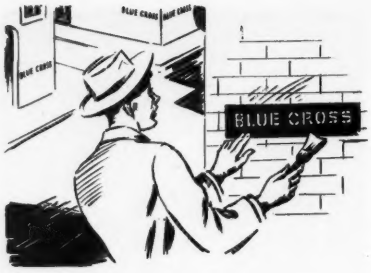
Now, multiple management is proving equally effective in converting to the postwar period. The junior board suggested, developed and put into operation the company's postwar planning department.

Democracy defeated dictatorship in war. Democracy in business has proved its superiority on the home front. Multiple management and similar plans of equal unselfishness will assure to employees in the future the same privileges of democracy in their jobs which our armed forces fought to maintain for them as citizens in a free nation. And the same principles applied in hospitals should bring effective results.

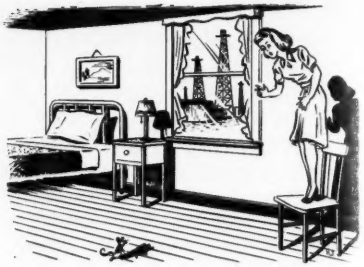
PROVED BY TEST

The plan of multiple management outlined in this article by Mr. Reid is far past the "interesting innovation" stage. It has been proved workable both by the originating company, of which Mr. Reid is director of personnel and public relations, and by some 500 firms in this country and abroad. It merits careful review by hospital directors now planning management realignments in order to meet specialized conditions of the postwar years.—Carl I. Flath

. . . enrolled miners, farmers and drillers



. . . painted blue slogans on every building



. . . sharing a room with a harmless roommate

THEY WILL SIGN UP, BUT—

MRS. IRENE F. McCABE
PUBLIC EDUCATION DIRECTOR, GROUP HOSPITAL SERVICE, INC., ST. LOUIS

CAN YOU WIELD a paint brush? Do you own a pair of hip boots? What's your weight and how tall are you? Do you have a jealous wife? Are you afraid of mice? Strange questions are these which Elmer Nester, associate director of the St. Louis Blue Cross plan, asks applicants for out-state enrollment work, but they have brought results as shown by the record of the plan in the last two years.

The area covered by St. Louis in Missouri and southern Illinois is divided among five district supervisors. These men must bring Blue Cross to miners, sharecroppers, factory workers, farmers and oil well drillers, in towns with hospitals and in areas where there is no hospital for miles around. The men must travel over dirt roads, climb down mine shafts, invade the section of Missouri infested with osteopaths and come up with Blue Cross applications—and they do.

Barnum had nothing on Blue Cross. Each man carries among his equipment a can of blue paint and a metal stencil, 3 feet by 5 feet, bearing the words, ENROLL IN BLUE CROSS NOW in anything but small letters. When plans are set for the enrollment of a community, out comes the can of paint and store windows, sidewalks and buildings glow with the message. Recently, in New London, Mo., J. R. McKnight, whose sales background would fill a book, painted signs on every store in town except an undertaking establishment (it sold its own hospitalization policy).

It is not easy to convince civic leaders in communities in rural areas that their people need Blue Cross protection, but once convinced their cooperation is wholehearted. A typical town is New London (population 1,005) located in Ralls County about 60 miles from Hannibal and Louisiana, where the nearest hospitals are located. After several calls on civic leaders, Mr. McKnight met with the board of aldermen and proposed Blue Cross as a community project for residents of New London.

The board voted unanimously to sponsor Blue Cross for the city and appointed the city clerk to serve as the group treasurer. An advisory council was appointed and active solicitation went on for a week.

Blue Cross "nurses" who help with individual solicitation in plants and small towns are a sturdy group. Any one of the 10 girls may spend one enrollment week interviewing employees in an elegant suite of offices—and the next week find herself in an oil boom town where she shares her room with furry four-legged animals. Recently, one of the girls spent the night perched on a straight chair after the hotel clerk had assured her that her roommate "ain't gonna hurt yer."

Full page advertisements donated by local merchants or the newspapers are run; in every community where enrollment has been successful, the newspapers have cooperated to the fullest. Lucian Smith, editor and publisher of the DuQuoin (Ill.) *Evening Call* is responsible for spreading Blue Cross to Pinckneyville and Sparta where community groups are being formed currently.

The towns of more than 10,000 population in Missouri can be counted on one hand. Most of them have well under 1,000 residents. These persons are still a trifle skeptical of new ideas, although the radio and national publications have made them more health conscious.

Blue Cross, however, has more than made a dent in out-state enrollment. Through the Farm Bureau, the automobile club, community groups and small firms, 75,000 members outside metropolitan St. Louis are protected.

Stories (like the one heard in DuQuoin recently by a Blue Cross representative) of the man who was spending his thirty-seventh day in an oxygen tent as a Blue Cross patient, create more real interest than all the ballyhoo and enrollment ideas the office can think up. The record tells the best story: during 1945, Group Hospital Service paid hospital bills for more than 8,000 cases in out-state hospitals as compared with 5,000 in 1944.

Rural areas will accept Blue Cross—but it takes time, patience and ingenuity to enroll them.

Eight Years' Experience in New York with LICENSED PAID AIDES

STELLA M. HAWKINS
SECRETARY, NEW YORK STATE BOARD OF NURSE EXAMINERS, ALBANY

THE RECENT WAR has taught many things in the hospital world as well as in the world at large. How to give nursing care to patients in hospitals with a dwindling supply of registered professional nurses and a steadily increasing number of patients has worried hospital administrators and others responsible for nursing service during these troublesome years. In many institutions wards have been closed and patients either turned away or placed closer together in the remaining wards to stretch the available nursing power.

Prior to the war considerable thought was given to the use of workers other than registered professional nurses for giving care either directly or indirectly to patients. Studies had been made and many articles written about the number of non-nursing duties constantly being performed by nurses, which took their time away from nursing and reduced the amount of actual nursing care they could give to patients. This made the cost of professional nursing care seem prohibitive to many. Analysis of these duties has shown that many did not involve nursing, but did contribute to the welfare of the patient and could be executed by men and women without nursing preparation.

Some of the duties required some nursing skill, but less than that of the professional nurse. Reassignment of these activities would leave the professional nurse more time and opportunity to exercise her skill in the care of patients, thus contributing both to the wellbeing of the patient and to the satisfaction of the nurse, who would be nearer to achieving her ideals of nursing service. Skilled nursing care has been considerably stretched by the use of volunteer aides who have been taught certain nursing procedures and have made a contribution of inestimable value during the war years. Persons with some training or with training and experience as practical nurses have been used for the care of the less acutely ill.

Increasing recognition is being given to the need for at least two types of workers to give direct care to the sick as well as another group to assist indirectly by doing the many essential but non-nursing duties. New York recognized this need 10 years ago and the State Nurses Association took the initiative in having the existing nurse practice act, which was merely a protection of title, repealed. A new act, providing for the licensure of all persons who nurse the sick for hire, was substituted.

Countless hours of study and discussion were given to the subject before a bill was drafted and introduced into the legislature. Discussion groups included practicing physicians, state and county medical societies, state hospital associations, lay users of nursing service and professional nurses engaged in various fields of nursing—institutional, industrial and public health. From the beginning, it was agreed that all who nurse the sick should be taught how to care for the sick and that all who nurse for hire should be licensed; those financially less able to employ nurses and those ill with some chronic disease are as much entitled to appropriate nursing care as are those who can afford to pay or who are acutely ill.

It was agreed that men patients as well as women should have good nursing care and that men as well as women nurses should be prepared. Up to this time, many hospitals would not think of permitting anyone except registered nurses to care for their women patients, but it was not at all uncommon, even in the best institutions, for an untrained man employee, known as an orderly, to execute all kinds and degrees of nursing procedures on the men patients!

Recognition of the need for a second type of nurse brought with it the need for preparing that nurse to assume the duties demanded of her. A committee representing medical, hospital, nursing and lay groups worked out policies and regulations, which should govern schools for the training of practical nurses as well as a general course of study and experience.

Since the administration of the professional laws comes directly under the Department of Education in New York, the tentative course of study and regulations, after approval by the varied groups, were submitted to the department with recommendations that these be approved by the Regents of the University of the State of New York. In submitting them for approval, the associate commissioner pointed out that they should be considered as tentative and that the ultimate course of study would have to be determined after all had practical experience in its administration. He emphasized that this was a pioneering venture with few examples anywhere in the country to serve as an example. The proposed course of study was not considered ideal, but subject to modification as experience developed.

The minimum requirements are

few and simple. In general they provide for:

1. Incorporation of the school or of the institution which conducts it.

2. A minimum enrollment of 20 pupils. This discourages the very small institutions which have little of value to offer as a school situation.

3. Suitable resources to provide for educational and other equipment.

4. Acceptable faculty with all nurse members registered professional nurses and graduates of registered schools. A school of nursing cannot be better than its nursing faculty. Graduation from a registered school in and of itself guarantees neither teaching ability nor knowledge of teaching methods. All instructors should have had courses in education and have records of proven ability as teachers.

5. Length of course to be not less than nine or more than 18 months. The length of course should be determined by and in proportion to the variety of content which is possible.

6. Preliminary education admission requirement is completion of at least the eighth grade or the equivalent. While it is desirable to admit pupils who have had some high school work, it is not wise to admit those who meet the requirements for professional nurse schools unless the applicants have been fully informed about both types of courses and the choice is their own. From a teaching standpoint it is desirable to have as little divergence as possible in any one class either in ages or educational background because teaching methods cannot be adapted to fit all members of a widely differing group.

7. The entire course to include a minimum of 200 clock hours of classroom work and at least six months of experience in a general hospital caring for men, women and children. Classwork is to be divided much as follows:

Care of self	8 hours
Behavior and working relationships	8 hours
Housekeeping	30 hours
Food and cooking	45 hours
Elementary nursing	90 hours
Care of the mother and newborn infant	8 hours
Care of children	5 hours
Care of convalescent, chronic and aged patients	6 hours
	200 hours

Experience is to be confined to the care of convalescent, chronic and mildly ill patients and to maternity patients after the fifth day following delivery.

The difference in purpose between a school to prepare practical nurses and one to prepare professional nurses should be kept in mind. The course for the former should be considerably shorter and simpler than the latter inasmuch as its graduates will be expected to perform simpler duties and for less remuneration than professional nurses. For this reason pupils may enter a practical nurse school with less formal general education than those admitted to a professional school. Pupils should be just as carefully selected, however, from a standpoint of personal fitness and health.

The work of the graduate practical nurse may be as important to society as that of the professional nurse, but hers is a different contribution. The instruction given her should be different in content and method, but of equal quality. Because she has had less formal education prior to entrance to the practical nurse school, her teachers must be skilled and capable of selecting subject matter with discrimination and of presenting its complex content in a simple manner.

In order to have the instruction easily understood, instructors are urged to keep so far as possible within the vocabulary of the pupils (using lay terms for parts of the body). This system places a minimum strain on pupils of limited background with a comparatively short time for covering the course. It is important that pupils concentrate their attention upon the nursing principles and procedures, rather than upon acquisition of a new vocabulary. The suggested outline of subjects for classroom teaching prepared by the Department of Education is set up on this basis with the titles of courses given in simple terms.

Much thought was given to the proportionate hours to be devoted to the various subjects. Considerable emphasis is placed upon housekeeping and cookery because the practical nurse in the home may be expected, under some circumstances, to perform these duties in relation to the family as well as to her patient. If a patient is so acutely ill as to require the entire time of the nurse, the case is probably one which should be hospitalized or have the services of a professional nurse. The province of the practical nurse is with the chronic, convalescent and mildly ill patient—never with the acutely sick, unless as an assistant to the professional nurse.

Chronic and other mildly ill patients, however, may require almost any nursing procedure, so the practical nurse needs to be taught all common procedures not requiring the use of intricate mechanisms or involving serious danger of infection; hence, there should be a generous allowance of hours for the teaching of nursing principles and procedures.

It is not considered necessary for her to have an extensive knowledge of medicines because few medications are given commonly to chronic patients. A practical nurse employed in an acute hospital should not be responsible for administering medications. Even if attendance at medical lectures and clinics is possible, it is not considered advisable to include these in the practical nurse pupil's experience because extraneous matter tends to bewilder and confuse her and to give her a mistaken concept of her proper functions.

Several different types of schools for the training of practical nurses have been registered and are operating in New York State. Currently 12 schools are registered. Five of these are in hospitals which do not have and are not suitable for schools for professional nurses; the remaining seven are central schools in which the pupil enrolls for the course, has the first three months of study at the school and the practice period of six to nine months in an approved affiliated hospital. The entire training is the responsibility of the central school, although the supervision and teaching in the hospital are given by qualified nurses in the hospital

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During the war, it was determined that A-C-D blood, which had been stored for more than a few days, could not be centrifuged without greatly increased hemolysis.† Obviously, Cutter Sediflasks are the logical answer, because—

1. Easy, natural sedimentation afforded by Sediflasks doesn't damage cells. Hemolysis is minimal, with less free potassium likely to invade plasma.

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3. "Hourglass" shape reduces area of contact between cells and plasma. Maximum amount of plasma can then be aspirated off without centrifugation.

With A-C-D Solution, plasma from blood not administered within 30 days may be aspirated off. Why not call your Cutter distributor at once?

* *Acid-Citrate-Dextrose.*

† *Reported by the Blood and Plasma Department, United States Naval Medical School, Bethesda, Maryland.*

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who are acceptable both to the central school and to the State Department of Education.

These central schools differ from each other in organization and functions. Three are administered by Young Women's Christian Associations, two by State Technical Institutes, one as a central school in a large city's Department of Hospitals and one by a board of education as an adult education program. This last program is well described by the nurse director of the school in the May 1945 issue of the *American Journal of Nursing.*

Cover Similar Fields

Each school works out its own program and, while there are distinguishing features about each, in general they all cover essentially the same fields of classwork and experience. Some have a period of affiliation with a chronic hospital and others have the major experience in an acute general hospital with pupils being carefully assigned to the care of only convalescent or chronic patients. The required hospital experience is distributed much as follows:

Adult medical and surgical nursing (chronic and non-acutely ill cases)	16 weeks
Care of maternity patients, mothers and babies, after fifth day	4 weeks
Care of children	2 weeks

For men pupils six weeks' care of urologic cases is to be substituted for the maternity and child care required for women.

The remaining weeks of clinical experience should be assigned according to what is available and appropriate for the practical nurse. The following types of experience are desirable additions:

Additional care of children	2 weeks
Nursery school	1 to 2 weeks
Cooking and serving food including infant feeding	1 to 4 weeks
Occupational therapy	1 to 2 weeks
Care of chronic mental patients	4 to 8 weeks

Schools for practical nurses exercise their own discretion regarding age of pupils enrolled. The age range is wider, however, than in the professional nurse schools and women up to 50 have proven their ability to complete the course satisfactorily.

During the war years, the practical nurse schools suffered in their enrollment as they could not compete with the high wages offered in defense work and other jobs. Immediately following Pearl Harbor, the nurse law was amended to make it possible for any person, even if unlicensed, to practice nursing for the duration of the war. This provision and the ready employment of unlicensed persons by many hospitals affected adversely the number of women entering practical nurse schools.

In contrast, the registered schools for professional nurses flourished during this period, receiving assistance never before contemplated, not only financially but in the extensive publicity program for recruitment. The practical nurse schools that survived are now beginning to have more applicants and with the increasing demand for more trained personnel both in hospitals and homes, the future for these schools and for their graduates is promising. The present production rate is not adequate to meet the needs.

When the law became effective in 1938, there were certain provisions made for licensing by waiver those who, though perhaps untrained, had been earning their living by the practice of nursing. About 18,800 practical nurses were licensed by waiver. Some of these had had a partial course in a registered nurse school but for various reasons had never completed the course. Others had received no formal training but were making a valuable contribution to the community through their years of experience and devotion to duty. The waiver period was open for three years.

Applicants since that time must have completed the course in an accredited school for the training of practical nurses, or must have completed a course "determined by the department to be the equivalent thereof." This equivalency clause gives authority to admit to the practical nurse licensing examination graduates of similar practical nurse courses accredited in some other state or persons who have completed in a registered school for professional nurse students, work equivalent to that required in a practical nurse course.

Since the termination of the war we have had numerous inquiries from service men and women who were trained in the Army, Navy, Coast Guard and Maritime Service to care for the sick and wounded of those services in conjunction with the medical and nursing corps. Anticipating these inquiries the national nursing organizations had studied the courses given and made certain recommendations for the licensure of these people as practical nurses. Outlines of the course content in nursing preparation as given by each of the services and other factual material were compiled. These outlines were cleared with the appropriate authorities of each service concerned and approval was obtained to consider the material as the authentic statement of the several services.*

Accepted in New York

New York accepted the recommendations in general and, under its equivalency clause, has been able to consider applications from these men and women who have had the prescribed courses and experience. The candidate is required to submit the original discharge record, separation qualification record and any certificates issued by the service schools with photostatic copies of each document. After comparison, the originals are returned to the applicant. Because the law specifies good moral character as a requirement for a license, only those persons discharged under honorable conditions are considered.

For the most part, these persons have been well trained. In some areas they have had much more training than is given in the regular practical nurse schools and in other areas the training is less. It is expected, however, that these persons who have already rendered service of inestimable value while in uniform, will continue to give the same high type of service when licensed as practical nurses.

*The compilation is available in mimeograph form under the title, "Training of Auxiliary Workers in the Care of the Sick—Army, Navy, Coast Guard, Maritime Service," and may be obtained from the American Nurses Association, 1790 Broadway, New York 19, for 30 cents.

As in the history of registered nurses when laws to license them were first enacted, the initial group forming the large nucleus was licensed by waiver of regular requirements. In the nearly eight years since the New York law was enacted in 1938, about 2,200 additional practical nurses have been licensed by examination, including both graduates of the accredited schools and those meeting the "equivalent" requirements. The number is now being increased only by those meeting definite requirements as to preparation and at the rate of about 400 annually, which is approximately 10 per cent of the entire number of nurses newly licensed in this state each year. There would seem to be little reason therefore for the fears of a few registered nurses that their professional careers are being threatened. Indeed, the trained practical nurse is welcomed by the registered nurse who has thought the question through and who is honestly anxious that the best available nursing care be provided for all.

Proverbial Ostriches

Those registered nurses who oppose the preparation and licensing of the practical nurse are the proverbial ostriches who refuse to recognize that a group of untrained and often ignorant workers have engaged in nursing since the beginning of time and that such persons are of greater danger to the registered nurse and to the community than those who have been carefully selected and trained for their duties and responsibilities.

Some hospital officials have felt that it is unwise or even dangerous to permit practical nurses to care for patients in a hospital, although it might be safe to employ practical nurses in the home. It is difficult to follow such reasoning. No good hospital is without some efficient registered professional nurses who can supervise the activities of the practical nurses, but in a home there is usually little or no supervision and even the doctor's calls may be infrequent.

Some hospitals, on the other hand, have leaned far the other way and employed practical nurses and other auxiliary workers out of proportion to the number of registered professional nurses on the staff. In some instances, this has been an effort to employ cheaper help with little regard for the dangers involved or for patient and community satisfaction. A reasonable and safe balance of registered nurses and practical nurses on the staff will permit economic use of the kinds of skill needed and the quantity of each needed. Adequate supervision of both groups is important and thoughtful analysis of duties and assignments must be made.

Duties which do not require the skill of either of these groups should be assigned to non-nursing personnel who in turn can have "on-the-job" training to make them proficient in carrying out their duties. This latter group would not be practicing nursing and would not need to be licensed nor would they qualify for licensure.

At the present time there are 20 states* which have provisions in their law for the licensing of practical nurses or attendants. Many other states are introducing such legislation or are preparing to do so. There is a definite nation-wide movement toward licensure of all persons who practice nursing for hire.

*American Journal of Nursing, Vol. 44, pp. 7-8 (Jan. 1944) and Vol. 45, pp. 1041-1043 (Dec. 1945)

It Pays to Educate

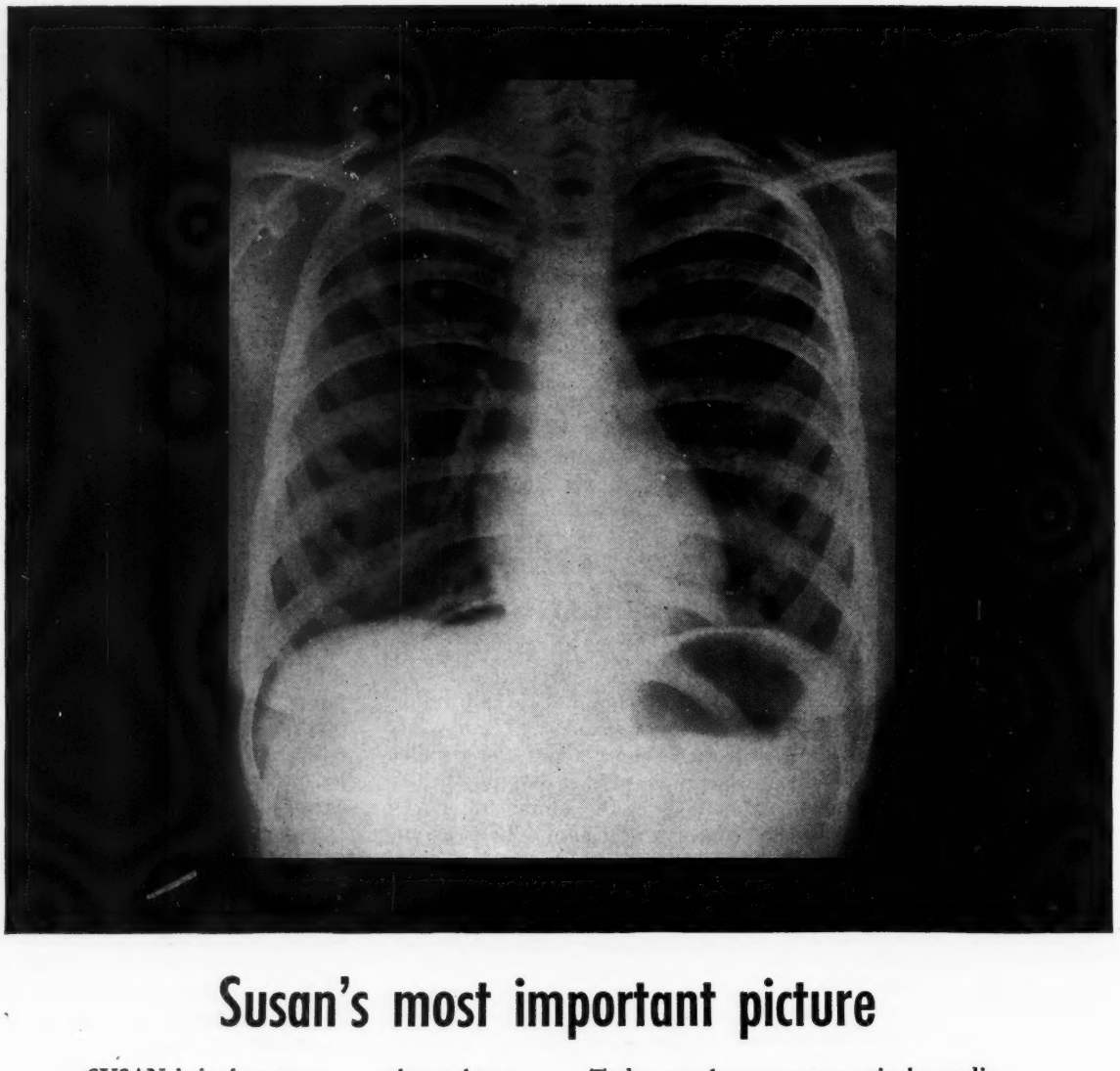
ALTOGETHER TOO OFTEN I have heard hospital administrators make the statement: "The less your trustees know about the detailed operations of your hospital, the better it is for the administrator." Of course we all know this is an unsound approach to good hospital administration as we all recognize that the board of trustees must be, in final analysis, the governing body and so assume the legal as well as moral responsibilities for complete operation of their hospital.

Therefore, I feel that it is not only the duty but the responsibility of every hospital administrator to provide his board of trustees with every medium of education that will better qualify them to serve as trustees. We here at Miami Valley Hospital provide our board of trustees with the "Trustee Forum," published monthly by the *Modern Hospital*, and in October of 1945 subscribed to HOSPITALS, the official publication of the American Hospital Association, for all of our 36 trustees, our auditor, comptroller, personnel manager, purchasing agent, and assistant director.

This small investment has returned big dividends, both from the department heads and the trustees. It has been very gratifying to find trustees calling the administrator on the telephone asking for an explanation of certain types of legislation proposed and commenting favorably at trustee meetings on work that is being done in other hospitals and discussing the advisability of such a program in our own institution.

It is my firm conviction that every hospital trustee should receive regularly a copy of HOSPITALS. —***O. K. Fike,*** director, Miami Valley Hospital, Dayton, Ohio.

THE JUNE ISSUE of HOSPITALS will present a special section on poliomyelitis in cooperation with the National Foundation for Infantile Paralysis. Experts in the field will cover such phases of the problem as organization of community resources, care of stricken persons in general hospitals, the role of the National Foundation, the nurse's responsibility to the patient, the treatment of poliomyelitis, and recent developments in research on this challenging disease.



Susan's most important picture

SUSAN is in her teens . . . when tuberculosis strikes most often . . . and the watchful physician does not depend on physical examination alone; he draws on the skill and knowledge of the radiologist.

The armed forces, too, are firm believers in chest radiographs. Every one of the 14 million men and women in war service was given a radiographic chest examination on entry . . . has another when mustered out.

Today, nearly every community has radiographic equipment available to serve physicians in its vicinity. And Kodak manufactures high-quality x-ray film, chemicals, and intensifying screens for the profession . . . capable of giving the maximum detail and contrast for easier, surer interpretation.

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Plans Ask for Reindorsement of SERVICE BENEFITS

NEARLY SEVEN MONTHS of reconversion experience had made it plain that Blue Cross plans were up against some first class obstacles. If they were to add 60 million subscribers to the 20 million-plus already enrolled, they needed:

- Reassurance that the principle of service benefits would survive today's strains.
- A workable basis for cooperation with new medical care plans, particularly those sponsored by the medical profession.
- More money with which to push enrollment into new areas.
- Closer teamwork among the 86 plans in the area of reciprocity.

It was at the end of nearly seven months of reconversion that executives of 66 plans met (March 25-27) in Cincinnati for the semi-annual Blue Cross conference. Discussion was pointed and some of the dissents were vigorous. An overwhelming majority nevertheless departed with renewed confidence, after endorsing the performance of the Hospital Service Plan Commission under John R. Mannix and that of the commission staff under C. Rufus Rorem.

Service Benefits. As the No. 1 principle on which Blue Cross operates and grows, service benefits had been threatened lately from three sides.

In times past, when unoccupied beds were a problem, the influx of Blue Cross patients was an unmistakable boon. Nor did it matter much if at times the bargain bundle of service benefits was dispensed at slightly less than cost, for Blue Cross patients accounted for but a small proportion of a hospital's total service load. The bulk of patients paid separately for each service used, and this provided a large area of flexibility in adjusting revenue to expenses. But as the percentage of Blue Cross patients increased, the area of flexibility decreased. Pressed by rising costs and the need of new income, many an administrator has found himself looking askance at service benefits.

During the same period there has been an increasing demand that hospital care and medical care be wrapped into a single package. To satisfy this demand in a hurry, both hospitals and plans in some areas have slackened their resistance to straight indemnity coverage.

Finally, the American Medical Association's early plans for a national health program, announced in February, were disturbing. Insurance companies offering only indemnity coverage were invited to seek official approval. One condition of approval would be local medical society control of medical services—and it is well known that the leaders of many local medical groups make little or no distinction between service benefits and socialized medicine.

In the face of these developments, all executives present considered that a time had come for clarification. It was widely contended that Blue Cross could not proceed in its present role unless it might continue to stand solidly on a foundation of service benefits. Accordingly the following resolution was addressed to the Board of Trustees of the American Hospital Association:

THAT they (the trustees) strongly reaffirm the principle that Blue Cross contract service benefits for medical and surgical

Active in Extension of Canadian Blue Cross

THESE AND OTHER Canadian delegates were especially interested in conference action to establish a Canadian office of the Commission to stimulate coordination and development of Blue Cross in the Dominion.

E. Duncan Millican (far right), chairman of the Canadian Development committee, will handle preliminary arrangements in consultation with the Commission.

Mr. Millican, executive director of Quebec Hospital Service Association, Montreal, received a telegram in Cincinnati informing him that a bill had been passed by the Quebec Legislative Council giving the Montreal plan authority to operate companion programs covering nursing and dental care, as well as medical or surgical services. So far as is known, this is the first Blue Cross plan authorized to offer nursing or dental coverage.

Shown here are Phillip Durnford, assistant director, Montreal; Leo LeBlanc, enrollment manager, Montreal; W. G. Welsford, executive director, Vancouver; Ruth Cook Wilson, executive director, Moncton, and Mr. Millican.

patients using semi-private and ward accommodations in member hospitals should be provided without extra charge to the patients. Contract service benefits include the basic services of board and room, nursing service, operating rooms, all drugs and dressings; also, with permissible limitations, such other forms of institutional and professional care as are specified in the contracts.

THAT the American Hospital Association and the Blue Cross Commission jointly establish an equitable method or methods of reimbursing hospitals that provide service benefits (not cash benefits) to Blue Cross members, and

THAT the American Hospital Association and Blue Cross Commission jointly accept the immediate responsibility of effectuating compliance with the standards of approval, and

THAT Blue Cross plans in which member hospitals do not provide benefits on a service basis be asked to show cause why approval should be continued by the American Hospital Association.

(Commission members and Association trustees are scheduled to meet for a discussion of all mutual problems June 28.)

"Official" Medical Plans. With hopes of learning more about the American Medical Association's program for approving prepaid medical care plans, the Blue Cross directors invited Thomas A. Hendricks, secretary of the A.M.A. Council on Medical Service and Public Relations, to discuss the program and answer questions.

They learned that: The medical association's role will be strictly limited to approving plans worked out by state and local medical societies; also that it looks with equal favor on commercial carriers and Blue Cross plans.

More Money. To help finance a stepped-up enrollment effort, the directors present voted to increase commission dues from 1¼ mills per subscriber contract per month to 2 mills, effective next August 1. While the additional revenue was not earmarked much of the discussion concerned an expanding program for the national enrollment office and public relations.

Teamwork. In other resolutions, (1) all plans were urged to adopt the revised interplan transfer procedure; (2) all plans were urged to adopt the interplan service benefit agreement now participated in by 34 plans; (3) all plans were urged to serve as clearing houses for admissions and payments for out-of-town subscribers in their own member hospitals, even though they are not prepared to reciprocate in furnishing service benefits to subscribers of other plans; (4) the Hospital Relations Committee was asked to draft recommendations for payment of out-of-town benefits which would adjust financial differences in payments to member hospitals by the various plans.

As luncheon speaker March 26, George Bugbee, executive director of the American Hospital Association, discussed Blue Cross-hospital relations. Pointing out that hospital costs have kept pace with rising prices, he warned that "in the face of a mild inflation, some adjustment will have to be made in the reimbursement of hospitals."

Name Public Education Director for Kansas Plan

Warren Healy, who has been affiliated with New York City's Blue Cross Plan for the past 10 years, has been named director of public education for the Kansas plan. As a pioneer staff member of Associated Hospital Service of New York, Mr. Healy conducted enrollment programs and supervised personnel training and coordination and writing of educational material.

New Comptroller for Kansas City Program

George W. Fundis, C.P.A., formerly with the firm of Ernst & Ernst, accountants and auditors, has been appointed comptroller of Group Hospital Service, Inc., and Surgical Care, Inc., the Blue Cross plan with headquarters in Kansas City, Mo., and its companion medical-surgical program.

Lieut. Governor Elected To Board of Directors

California's Lieut. Gov. Fred Houser was elected to the board of directors of Hospital Service in Southern California at the annual meeting of the plan in Los Angeles recently.

More Tuberculosis, Mental Benefits

"Blue Cross plan provision of a definite period of full benefits limited from 14 to 21 days would seem reasonable and would certainly provide that immediate relief for both tuberculosis and mental patients which would so encourage prompt treatment and improve the morale of the patient."

This statement advocating further progress in the liberalization of Blue Cross plan benefits for the care of tuberculosis and mental cases was the theme of an address by Louis H. Pink at the annual conference of the Tuberculosis and Health Association of New York March 21 in New York City's Hotel Pennsylvania. Mr. Pink, formerly Insurance Commissioner for the State of New York, is president of the New York City area's Blue Cross organization.

Those attending were informed that 30 of the 86 plans provide some degree of protection for mental and tuberculosis cases. The satisfactory experience of these 30 plans, said Mr. Pink, is evidence of the practicality of further liberalization at an accelerated pace.

In presenting his views, Mr. Pink brought out several reasons for the widespread exclusion of benefits for such care in the past.

"Blue Cross," he said, ". . . .can provide for its members only those services which the hospitals in each community offer to the public . . . in addition there has been a desire on the part of Blue Cross to keep the cost of broad service low by eliminating those diseases which are adequately provided for by government."

In this connection, Mr. Pink discussed the belief once held widely that it is dangerous to have mental and tuberculosis patients in general hospitals even though segregated in separate wards or pavilions. He pointed out that this belief is gradually being replaced by the more realistic attitude that the general hospital should be a center for the study and diagnosis of all types of diseases.

Present Session May Bring ACTION ON S. 191

AMERICAN HOSPITAL ASSOCIATION
WASHINGTON SERVICE BUREAU
1705 K Street, N.W., Washington

BECAUSE CONGRESS is not expected to adjourn before mid-July there is yet sufficient time for the House and Senate to act on S. 191, the Hospital Survey and Construction Act, during the present session, in the opinion of Representative J. Percy Priest, Tennessee, chairman of the Public Health Subcommittee, which was expected to conduct final executive sessions on that legislation during the week of April 29.

Representative Priest expects that the bill may clear the Interstate and Foreign Commerce Committee by mid-May. He believes that such action will permit ample time for vote by the House of Representatives, agreement on possible amendments by a joint conference committee, and final action by both houses.

S. 191 has pursued a delayed course. On January 10, 1945, it was introduced by Senators Hill and Burton and referred to the Committee on Education and Labor; on October 30 it was reported with an amendment. Still further amended, it passed the Senate on December 11.

In the House it was then referred to the Committee on Interstate and Foreign Commerce, whose Public Health Subcommittee concluded hearings March 13.

CPA Regulations

Specific government authorization through the Civilian Production Administration for all construction begun after March 26 is now required under the Veterans' Emergency Housing Program Order 1 issued that date.

There is exemption for hospitals only when the repair, alteration or construction is to be completed at a total cost—including labor—of less than $1,000. Projects which were begun before March 26 and which had part of the material incorporated into the building on the site may proceed without further authorization.

To handle construction requests, 71 district offices have been established by CPA. Applications for authority to construct Form CPA-4423, may be obtained at the nearest district office. When completed and returned these applications will be acted upon by the district construction committee, whose one function is to recommend to the district manager of the CPA the approval or rejection of non-housing building or repair projects over which the CPA has control.

It is expected that delays of two to four weeks might be encountered until committees are acting upon applications with regularity.

The district construction committees and construction field offices will pass on the essentiality and deferability of future building in an effort to channel as much scarce material as possible into the veterans' housing program. These advisory committees will include one member recommended by local government, one from general business, a representative of the builders of building material industries, the press and others. Each project is to be judged by local people.

All decisions can be appealed through the district offices to regional and national levels. The Washington office will pass on all applications for building in which the cost exceeds $1,000,000.

Approval results only in permission to proceed with construction. It does not allocate nor guarantee availability of construction materials. However, in cases of extreme necessity, if a hospital is unable to find needed materials the Washington office may, on application, issue a CC rating which will give some priority assistance. Otherwise materials must be obtained in a competitive market with other non-housing projects. It has been suggested that even those hospitals which are exempted from the authorization program file such application so that if priority assistance is necessary they will be eligible. No priority ratings can be had without a construction permit.

Wilson W. Wyatt, national housing expediter, believes that the limitation order will channel the materials available for non-housing use into essential rather than non-essential building. Fulfillment of this premise would recognize the urgency of hospital construction, but at this time no specific ruling has been made to insure that goal.

Regional directors and currently complete list of district managers to whom applications must be made are:

Region I: (Maine, Vermont, Rhode Island, New Hampshire, Massachusetts, Connecticut). Regional Director: William P. Homans, 55 Tremont St., Boston. District Managers: Philip W. Simons, 1597 Main St., Springfield, Mass.; Charles E. Walker, 8 Harlow St., Bangor, Me.; Bruce McMillian, c/o R.F.C., 119 Ann Street, Hartford. Conn.; George C. Vaughan, 814 Elm Street, Manchester, N.H.; James Q. Dolan, 75 Westminster St., Providence, R.I.; Edward H. Sargent, 42 Central St., Northfield, Vt.

Region II: (New York, New Jersey, Maryland, Pennsylvania, Delaware, District of Columbia (including Arlington and Fairfax Counties in Virginia). Regional Director: Ralph A. Parker, 43rd Floor, Empire State Building, New York City. District Managers: W. Arthur Riehl, 43rd Floor, Empire State Building. New York City; Earl R. Mason, 1132 Rand Building,

Buffalo; F. J. Holman, 112 State St., Room 1206, Albany; John A. McNulty, 20 Washington Place, Newark; Frederick Cohen, Post Office, Camden, N.J.; J. M. Leonard, Broad St., Philadelphia; J. F. Stephens, 1810 First National Bank Building, Pittsburgh; R. W. Willis, Room 301, Pennsylvania Office Building, Wilmington. Dela.; O. W. Carman, Room 307, 22 Light St., Baltimore; Edward M. Synan, Room 2051, Social Security Building, Washington, D.C.

Region III. (Ohio, Kentucky, Michigan, West Virginia). Regional Director: George A. Moore, 4th Floor, Union Commerce Bldg., Cleveland. District Managers: Glen W. Thompson, 4th Floor, Union Commerce Bldg., Cleveland; Louis W. Gehring, 1037 North High Street, Columbus, Ohio; J. Thomas Grace, 6th Floor, Big Four Bldg., 9th & Sycamore St., Cincinnati; Vernon H. Pfaender, Merchants Finance Building, 312 Summit Street, Toledo; John B. McGillis, 800 Boulevard Building, Detroit; Harry D. Rosenberg, 2175 Lake Drive, N.E., Grand Rapids, Mich.; Henry Edson, 1222 Reyburn Building, Louisville, Ky.; Alex H. Cooper, Chamber of Commerce Building, c/o F.H.A., Charleston, W.Va.

Region IV. (Georgia, North Carolina, Alabama, Tennessee, South Carolina, Mississippi, Florida, Virginia). Regional Director: John B. Reeves, 1606 Candler Building, Atlanta; O. M. McCullough, 1005 E. Main St., Richmond, Va.; Leonard H. Dille, 677 Shrine Bldg., Memphis; Chester O. Easign, 1105 Duilford Building, Greensboro, N.C.; Albert E. Douglas, 2065 Blossom St., Columbia, S.C.; Paul P. Henderson, 4th Floor, Dixie Carlton Hotel, 3rd Ave. & 23rd St., Birmingham, Ala.; A. G. McIntosh, 3951 Council Circle, Jackson, Miss.; C. L. Ledford, P.O. Box 4910, c/o P.B.A., Jacksonville, Fla.; P. Campbell Smith, 311 Hinson Ave., Tampa; Earl J. Robbins, 35 N.W. Second St., Civic Center, Miami.

Region V. (Illinois. Wisconsin, Indiana). Regional Director: Chicago Regional Office unfilled as yet. District Managers: W. Fred Stevens, 226 W. Jackson Blvd., Chicago; Karl Diehl, 201 West Adams St., Springfield, Ill.; Albert O. Evans, 826 Circle Tower, Indianapolis, Ind.; R. R. Valier, 161 W. Wisconsin Ave., Milwaukee.

Region VI. (Missouri, Nebraska, Iowa, Kansas, Arkansas, Colorado). Regional Director: William A. Holloway, 600 Mutual Bldg., Kansas City, Mo. District Managers: Robert B. Miller, 410 Old Customs House, St. Louis; Alga Hothern, c/o Mr. Jonas Graber, FHA, Topeka National Bank Bldg., Topeka, Kans.; Frank Epperson, 2nd Floor, Arthur Bldg., 210 South 18th St., Omaha, Neb.; Sam G. Davies, City Health Center, Markam & Gaines St., Little Rock, Ark.; H. O. Parsons, 708 Liberty Bldg., Des Moines, Iowa; Norman J. Gastellan, 523 Continental Oil Building, Denver.

Region VII. (Texas, Oklahoma, Louisiana, New Mexico). Regional Director: George L. Noble, 1221 Mercantile Bank Bldg., Dallas, Tex. District Managers: Emmett H. Hiett, 1221 Mercantile Bank Bldg., Dallas; George W. Chambers, 100 Transit Tower Bldg., San Antonio; Edgar G. Goforth, Electric Bldg., Room 1044, Houston; Walter P. Camp, c/o Chamber of Commerce Bldg., Fort Worth; Merwin T. Buxton, 215 Colcord Building, Oklahoma City, Okla.; Carl Stevens, 1932 North Boston Ave., Tulsa, Okla.; George A. Pettit, 1412 Masonic Temple Bldg., New Orleans; Murray H. Sprague, Rosenwald Bldg., Albuquerque, N.M.

Region VIII. (Southern California, Arizona, Utah). Regional Director: Louis M. Dreves, 703 W. M. Garland Bldg., 117 W. 9th St., Los Angeles; Irving Dix, 703 W. M. Garland Bldg., 117 W. 9th St., Los Angeles; John Young, 355 Civic Center, 1600 Pacific Highway, San Diego, Calif.; Arnold M. Seiler, 310 Atlas Bldg., Salt Lake City, Utah; Louis Myers, 108 Aluminum Plant Office Bldg., W. Van Buren Street, Phoenix, Ariz.

Region IX. (Northern California, Washington, Oregon, Idaho, Nevada, Montana, Wyoming). Regional Director: Edwin F. Halloran, 1355 Market St., San Francisco; Gilbert H. Kneiss, 1355 Market Street, San Francisco; Donald W. Carswell, 8306 18th St., Seattle, Wash.; De-Witt Wallace, North 120 Wall St., Spokane, Washington; Nelson English, 1840 S.W. Edgewood Road, Portland, Ore.; J. Wahl, 110 North 8th St., Boise, Idaho; Edwin St. Bender, 56 Boyd Place, Reno, Nev.; Jerome Locke, P.O. Box 729, Helena, Montana; Fred R. Kingman, 2345 Kalakaua Avenue, Honolulu 30, Hawaii.

Region X. (Minnesota, North Dakota, South Dakota). Regional Director: William L. Jensen, Midland Bank Bldg., Minneapolis; District Managers: Charles G. Sharp, Midland Bank Bldg., Minneapolis; Charles W. Randall, 210 Walker Bldg., Fargo, North Dakota; E. E. Seubert, City Hall Bldg., Sioux Falls, S. D.; Ramon Montaner, PRRA Grounds, San Juan, Puerto Rico.

House Committee Hears Dr. Smelzer

Dr. Donald C. Smelzer, past president of the American Hospital Association, appeared before the House Ways and Means Committee April 5 on behalf of the Association asking that employees of nonprofit hospitals be included in the federal old age and survivors' insurance program. Dr. Smelzer's testimony set forth the position authorized by the House of Delegates in November.

The committee expects to hear about 125 additional witnesses before recommendations will be considered for action. For this reason it is not expected that any decisive action will be taken during the present legislative session.

Limitation of coverage was advocated by William F. Montavon, director, legal department of the National Catholic Welfare Conference. He asked that inclusion be made optional with institutions whose members serve without pay.

Testimony of the Rev. John Martin, past president of the Protestant Hospital Association, concurred with the recommendations suggested by Dr. Smelzer.

Dr. Smelzer's remarks follow in part:

"At the time that old age and survivors' insurance was enacted, (hospitals) were in the most difficult (budget balancing) period in their existence. . . . Any additional payment substantially affecting expenditures seemed to be beyond their resources and it was therefore a general impression . . . that they should be exempt. . . . There was apprehension as to the precedent created by . . . a federal tax. This . . . has been met by the establishment of a federal trust fund and the designation of funds contributed by employers and employees as a contribution rather than a tax in the usual sense. . . .

"The American Hospital Association is at the present time organizing an independent pension plan. . . . We wish to call (to) the attention of the committee, as supporting evidence for the need for federal action, that in establishing an independent pension plan the actuarial cost to offer benefits equal to those offered under the federal program requires total deductions from employers and employees as far in excess of the present contributions under the federal program as to interfere seriously with providing satisfactory benefits by independent action.

"The pension plan being set up by the American Hospital Association in cooperation with the National Health and Welfare Retirement Association will require deductions totaling approximately eight per cent of the covered payroll in order to offer benefits for the low income group equal to those now provided by a total deduction of two per cent under the federal program."

A Significant Decline in MATERNAL DEATHS

From 1933 to 1943 birth rates increased from 16.6 per thousand population to 21.5 and the proportion of births in hospitals increased from 37 per cent of all live births to 72 per cent—a 95 per cent increase in hospital births. Highest was 97.3 per cent hospital births in Connecticut; lowest was 26.6 per cent for Mississippi. During the same 10-year period maternal death rates decreased from 61.9 per 10,000 live births to 24.5 (from 56.4 to 21.1 for whites, and from 100.0 to 51.3 for Negro). The maternal mortality decrease is more significant when it is realized that there was an increased proportion of first births and of births to young mothers, both of which contribute to higher maternal mortality.

Of 2,934,860 live births in hospitals in 1943, 72.1 per cent were attended by physicians in hospitals, whereas of 2,155,105 live births in 1935, 36.9 per cent were attended by physicians in hospitals.

Better chemotherapy, more blood transfusions, fewer operative interventions, better hospital regulations for asepsis reduced the deaths from infection. Better prenatal care, better diet and fewer operative maneuvers in eclamptic patients probably reduced the mortality rate for toxemias. Both infections and toxemic deaths, therefore, are subject to some control by hospitals through the adoption by the medical staffs of regulations as to consultation and other medical safeguards.

During the 10-year period the infant mortality rate dropped from 58 to 40 per 1,000 live births. This is a real and not a chance improvement, but it does not represent as great a decline as for maternal mortality.

Gooch, Marjorie: "Ten Years of Progress in Reducing Maternal and Infant Mortality," The Child 10:77-83, Nov., 1945.

Mouth Rinse, Tooth Powder That Prevent Decay

A mouth rinse and tooth powder is reported to combine simplicity of use with ability to prevent tooth decay. Patients using this method (still in the experimental stage) say their mouths "feel exceptionally clean." On dental examination their teeth are notably free of white matter and deposits usually present in cases of active decay. The rinse and powder contain a special form of ammonia, dibasic ammonium phosphate, which is *not* the common kitchen variety.

The number of Lactobacilli acidophilus in the mouth is rather generally believed to indicate the degree of susceptibility to tooth decay. The ammonia mouth rinse and tooth powder markedly reduces the number of these organisms.

The rationale of this preventive measure rests on some interesting observations and theory summarized in the following quotation "immunity to caries, or tooth decay, those earlier findings suggested, comes from tiny amounts of ammonia continually present in the mouth. The ammonia comes from a small group of the protein building-blocks, known to scientists as amino acids. The lucky persons who are immune to caries have in their saliva enzymes capable of producing ammonia from certain of these amino acids." Another eighteen months to two years will be required before the effectiveness of the new method can be reliably appraised.

Another possible preventive for tooth decay is described in the February 18, 1946 issue of *Time*. Northwestern University dentists experimented with an acid decreasing synthetic vitamin K, which was spread on chewing gum. In a series of 100 cases 55 students chewed the treated gum and 45 did not. After eighteen months the vitamin K chewers had 60 to 90% fewer new cavities than the others. This treatment, although used only in a very small series, appears to be more effective than the use of fluorine in drinking water.

According to *Time* the more difficult problem now is to determine a satisfactory method of giving preventive mericine than the discovery of the medicines themselves.

"Preventing Tooth Decay," Science Newsletter, 117 February 23, 1946.

Mortality from Appendicitis On the Downgrade

The Statistical Bulletin of the Metropolitan Life Insurance Company for February 1946 reports a marked decline in the mortality from appendicitis in the general population of the United States. About ten years ago the death toll annually was 18,000, whereas in 1943 for a much larger population the death toll was only 8,100. From 1940 to 1943 all states reported declines in the death rate per 100,000 population, the highest percentage of decline being in Rhode Island and Maine with 61.9 and 61.6 per cent respectively and the lowest in Alabama and Nevada with 26.9 and 18.7 respectively. In general the smallest gains in reducing the mortality were made by the southern states.

Recent improvements in the use of chemotherapy for cases complicated by peritonitis are largely cred-

ited with the reduction. Much credit is also due to the national educational campaign which has so effectively warned the public against use of laxatives in the presence of abdominal pain and has encouraged persons to seek medical advice early.

DDT Poison In Milk?

Dairy cattle grazing on DDT sprayed pastures may cause poisoning in users of their milk. The evidence is experimental only, and it is indicated that the butterfat portion of milk transmits the poison. Apparently goats (and perhaps cows) do not absorb DDT from the skin. Goats do not lick their skins, but cows do and thus might absorb DDT if the skin is sprayed.

Science News Letter 49:5, Jan. 5, 1946.

Say Vitamin A Can Be Synthesized

Fish may no longer be necessary to furnish man's needs for Vitamin A. A wartime secret, now revealed, indicates that Vitamin A can be synthesized. The product is 50 to 100 times as biologically potent as that obtained from codliver oil but only 1/10 to 1/30 as potent as pure Vitamin A crystals from natural sources. It is not yet commercially available.

Science News Letter 49:30, Jan. 19, 1946.

NOTES and COMMENT

Polio—The *Science News Letter* in a recent issue reports good results obtained by the use of 5 per cent carbon dioxide in oxygen in the treatment of infantile paralysis. The first patient was a 6-year-old girl with an acute encephalitis, bulbar and spinal poliomyelitis.

Because the result was so impressive, the procedure was tried in twelve other cases and in all but one "there was relaxation, prompt relief of pain, rapid return of muscle strength, early functional improvement and the patients volunteered the information that they felt well." The inhalations are given continuously for 24 to 36 hours or intermittently several times daily for one or two hours.

Five per cent carbon dioxide in oxygen is apparently a harmless procedure and a new method of treating infantile paralysis. No claims are made for the treatment since it has been given in such a small series of cases and the course of infantile paralysis varies markedly irrespective of treatment given.

Anemia — A newly synthetized vitamin, folic acid, is reported as the first synthetic substance which will quickly improve the blood picture of patients suffering with macrocytic anemia. Previously liver, liver extract, dried hog's stomach, kidneys and brains have "been the only substances which remedied this macrocytic anemia."

Anemia Remedy, Science News Letter, p. 279, November 3, 1945.

Thyroid—Thiobarbital is the second recent addition to drugs found to be effective in the treatment of hyperthyroidism (thiouracil was reported recently in this department).

Toxic reactions from thiobarbital are similar to those of thiouracil but symptoms from thiobarbital are about three times as frequent as from thiouracil. This has led to restriction of the use of thiobarbital to those patients who have been unable to tolerate thiouracil.

Bartels, Elmer C.: Use of Thiobarbital in the Treatment of Hyperthyroidism, JAMA 129:932-935, December 1, 1945.

Severe pneumonitis — Eight patients died among 19 known cases of a severe infection of the lungs in Louisiana in the winter and spring of 1943-44. It has now been demonstrated that the disease was caused by a newly discovered virus of the psittacosis-lymphogranuloma venereum group of viruses, recoverable from the living patients' blood and sputum and from the lung and spleen after death.

Olson, B. J., Surgeon, and Larson, C. L., Past Assistant Surgeon, United States Public Health Service: An Epidemic of a Severe Pneumonitis in the Bayou Region of Louisiana, Public Health Report 60:1488-1502, December 14, 1945.

CURRENT HEALTH CONDITIONS

A statement from the Division of Public Health Methods, U. S. Public Health Service, through the month of March, 1946

Smallpox. Smallpox has become a rare disease in recent years, only 346 cases being reported in the whole United States during the year 1945. The few cases that are reported usually represent some local outbreak which is rather quickly suppressed by widespread vaccinations within the affected area.

Two more or less distinct epidemics have occurred in the last three months. The centers of these epidemics are San Francisco and Seattle; both outbreaks were started by a soldier returning by air transport from Japan. In San Francisco the soldier arrived on December 28 and the eruption appeared the next day. Up to April 11 a total of 11 cases had occurred, including four from Navy transports during the first 11 days of April. The last local case occurred on March 11; no deaths have occurred. In the Seattle-King County area there were 34 cases and seven deaths between February 19 and April 7. There were two additional cases in Washington State outside of the Seattle area.

Epidemics of smallpox even of this size are extremely important because of the potential hazard of the spread of the disease among the considerable non-vaccinated population in that section of the country, and because both centers of the epidemic are ports and, therefore, involve the question of the spread of the disease to other countries throughout the world.

Diphtheria. Although diphtheria no longer manifests itself in sharp outbreaks, the continued rise in reported cases and deaths in various parts of the country represents a situation that has not prevailed for many years. For a period of at least a decade reports for each year and for the most part for each month have been less than immediately preceding years and less than corresponding months of preceding years. Throughout the past year nearly every month has brought reports in excess of corresponding months in immediately preceding years. Both case and death rates are on the increase.

In March of 1946 there were about 1,500 diphtheria cases reported, as compared with 1,200 for March of 1945 and 1,000 for March of 1944 and 1943. While not many data are available by age, it has been noted in some localities that more cases are occurring among adults and that the case fatality is increasing.

Meningococcus meningitis. Meningitis continued low through March, the 800 cases representing only about one-third of the numbers reported in March of 1944 and 1943 and considerably less than the 1,100 cases reported in March of 1945.

Measles. Measles reports were much higher in March of 1946 than in March of the preceding year, totaling approximately 140,000 cases this year. In March of 1944 there were 145,000 cases and 100,000 in March of 1943.

Four Books Telling How to PLAN A HOSPITAL

READING AND REFERENCE information on the planning of hospitals has been augmented during the past year by the publication of four books. Two of them have been previously reviewed in this section. The first, "Measuring Your Community for a Hospital," is a collection of articles compiled by the headquarters staff of the American Hospital Association; the second is a publication of the Department of Hospital Service of the Canadian Medical Association, entitled "Planning and Constructing the General Hospital."

Both books fill a very definite need, constantly expressed by community groups interested in having a hospital for their citizens. The Canadian booklet was checked and revised by a number of hospital architects and administrators with wide experience in hospital planning and construction. The major portion of the text deals with the plans of services and departments. The number of complete floor plans has been kept to a minimum for it seldom happens that a successful plan proves equally satisfactory in another location.

"Measuring Your Community for a Hospital" was designed in the first place in order to make available from the library a number of copies of the best collection of articles on this subject. These authoritative articles discuss how to determine the need for a hospital, its type and size, the organization and responsibilities of the governing board and the medical staff, and the necessity for competent architectural consultation in its planning and construction. This book serves as supplementary reading to Book I of the American Hospital Association's series, "The 1945 Hospital Review." Following the publication of this collection it was felt that the problem of actually planning the hospital needed to be further developed. The literature was carefully surveyed and another collection of articles on this subject was compiled under the title, "Planning the Community Hospital." The table of contents, which is reproduced on this page, will give an idea of the material covered in the discussion. Its purpose was to present the many facets to be studied in the planning of a hospital's physical form.

Table of Contents for
"Planning the Community Hospital"

The hospital building program.
Effect of orientation.
A chart of suggested interior finishes.
Functional planning of hospitals.
Planning a hospital to human specifications.
Modern trends in hospital planning and equipment.
Major trends in construction and plant operation.
Net area distribution for a 50-bed general hospital.
Time saver standards; a symposium.
Departmental planning; a symposium.
Modern pediatric standards call for wise planning for child care.
St. Catherine's Hospital, Kenosha, Wis.
Ponca City Hospital, Ponca City, Okla.
Washington Hospital, Washington, Pa.
Suggested plan for a 15-bed hospital: Department of Public Health of Alberta.
The hospital; a line assembly for medical care.
Planning for integrated services: A health center unit.
Planning for integrated service: A 50-bed rural hospital and health center.
Planning for integrated service: The district hospital.

The fourth help for prospective hospital builders is the Modern Hospital's recent book, the "Modern Small Hospital and Community Health Center," which is reviewed at length in this section. All four of these books are available on loan from the Bacon Library of the American Hospital Association.

On Hospital Architecture

"THE MODERN SMALL HOSPITAL AND COMMUNITY HEALTH CENTER," Modern Hospital Publishing Co., Chicago; 1946. $7.50, 138 pages.

"That which is worth doing at all is worth doing well" might be considered the theme of this recent publication. Literature on hospital architecture has gained a very definite contribution in this excellent presentation. Most of the source matter is supplied by the 1944 Architectural Competition of the Modern Hospital Publishing Co.

Plans submitted are for 40-bed hospitals with possible future expansion of 20 beds. This capacity was selected since a hospital of this size is one of the most difficult to properly plan, construct, staff and operate, yet one very definitely needed by many communities. As each contestant chose a definite site for his prospective hospital, the reader may concentrate on those most adaptable to the needs of his particular situation.

The fore part of the book includes 10 chapters on the many problems involved in planning and administering a small hospital. These subjects and authors are well chosen. As more than three fourths of the nation's present hospitals have less than 100 beds, the need of better planning for the small hospital is alarmingly evident.

Dr. Mountin sets forth the probable future need of the 40-bed hos-

pital in a striking manner in the following: "1—that a planned development of hospitals will replace the opportunistic approach which up to now has been followed; 2—that beds will be concentrated in the smallest number of institutions consistent with adequate distribution; 3—that hospitals below a minimum size, perhaps 40 beds, will either be brought up to this level or eventually pass out of existence; 4—that, in time, practically no small hospitals will be found in the larger centers of population." Time alone will tell whether his suppositions are correct or not.

A thorough community survey is a "must" according to Dr. Carter, who also points out that the best possible survey will fail to accomplish anything unless "its accepted recommendations are implemented as promptly as circumstances will permit, through community action."

The advisability of employing a consultant is emphasized by Everett Jones, who writes, "In the days to come, hospitals will pay fewer but better employees much higher wages than in the past. This will call for more efficient and adequately equipped plants that can be operated with fewer employee hours per patient."

Other sections discuss architecture, design, materials, organization, finance, equipment, the professional and administrative organizations and in one entitled "The Patient's Needs," Carl A. Erikson stresses the need for remembering that the patient is the focus of the entire efforts of the hospital.

The actual hospital plans themselves are of sufficient size to be easily read. While only a few of the contestants followed the rather familiar architectural lines that we are accustomed to associate with hospitals, the great majority presented drastic changes, which, while as yet untried, seem quite practical.

The contestant in most cases provides a statement that describes the contemplated community, its needs and peculiarities. This provides considerable assistance in studying the plan. Statements by the jury and editors show that every detail has been given most careful consideration.

SERVICE INTERRUPTED

Because of construction now going on in the library, it has been necessary to suspend the service temporarily. A second floor is being built in the present room, which is of two-story height, having been a gymnasium in the days when the headquarters building housed the Chicago Latin School. Notices have been sent to inquirers stating that the sending of information would be delayed until it was possible to get into the library again.

For example, great emphasis has been placed on locating the patients' rooms where they would be removed from as many disturbing noises as possible. Also special attention is drawn to the arranging of services so that one nurses' station could adequately care for patients on all services during the night or periods of low occupancy. The majority of the plans indicate that the contestant had an excellent comprehension of the problems faced by administrators of small hospitals.

Some of the plans in the latter part of the book include facilities for the use of the local health officer and his staff. Too, there is provision for offices for doctors and dentists and a complete outpatient department. These, too, show a good grasp of the community health problems and it is quite likely that such institutions will be better able to serve their communities than the present type of hospital.

Because of its unusual size and striking binding, this volume may easily become a show-piece allowed to remain on the book case or desk. However, may we suggest rather, that it be closely studied from cover to cover by every administrator and person interested in providing better hospital care for the people of his community.—W. G. S.

Organizing for Social Welfare Programs

COMMUNITY ORGANIZATION FOR SOCIAL WELFARE. Wayne McMillen. Chicago, the University of Chicago Press; 1945. 658 pages, $4.75.

Mr. McMillen is professor in the School of Social Service Administration at the University of Chicago and also is a commissioner and vice-chairman of the Chicago Housing Authority. The hospital as a social agency within the community is vitally interested in the broad planning of the community to meet the varying needs of the people. The hospital administrator as a leader in the community needs to take a part in the discussion of projects which will affect the health and welfare of the inhabitants.

In this book the author tries to show how people sincerely interested in improving the society in which they live can best work together to achieve this purpose. Among the social work processes, community organization has received far less attention than either care work or group work. The four principal questions which a community asks itself are: How do we determine community needs? Which needs are most important? How can we develop a promising plan of action? How can we put our plan into action?

Mr. McMillen evaluates the concrete methods used in the day-to-day job of those engaged in community organization and in analyzing group behavior and identifying the powers that make groups respond and go into effective action. He describes the structure of the various agencies which must work together to organize the community into an organic whole.

Each chapter has a list of selected readings and of documents which have been used. Much of this documentary material is drawn from reports not elsewhere in print; thus the book is an excellent source for this fugitive material.

Duplicates of *Transactions*

The library of the Woman's Medical College of Pennsylvania, Philadelphia 29, has for disposal some duplicate copies of the *Transactions of the American Hospital Association*. They are for the years 1923-1943, with the exception of 1933. If any hospital is in need of any one or more of these copies to complete its set, requests may be made directly to the medical library at the above address.

News

TWO ROCHESTER HOSPITALS PROVIDE DISABILITY TEST CLINICS FOR V. A.

Nearly 1,500 veterans were processed at clinics operated by two Rochester, N.Y., hospitals between March 4 and March 30, according to Dr. Frank C. Sutton, acting director of Rochester General Hospital.

Rapid demobilization in western New York had resulted in overcrowding of processing facilities. On February 28 the Veterans Administration at Batavia requested help from Rochester General and the Genesee Hospital in processing local veterans who were applying for disability ratings.

Rochester General's clinic opened on March 4 and that at the Genesee Hospital on March 11. Both operated on a four hour day, Monday through Saturday, until the backlog was eliminated.

Since the purpose of the examination was to determine disability based on complaints, a complete physical examination was not done routinely. The hospitals discovered that most veterans required referral to the neuropsychiatrist in the clinic. Diagnoses were recorded in each case and the degree of disability determined later by the regular rating board of the Veterans Administration.

Physicians serving in the clinics were paid on a per diem basis. The hospitals were paid on a fee basis.

Between 30 and 60 veterans were examined daily in each clinic by a team of eight to ten doctors including general practitioners, and specialists in ophthalmology, otolaryngology, neuropsychiatry, cardiology and orthopedics.

Similar clinics have been established at Meyer Memorial Hospital, Buffalo, Syracuse General Dispensary, Syracuse, and in Binghamton. It is reported that the Veterans Administration is planning to establish a permanent veterans' clinic at Rochester, where ambulatory diagnostic treatment facilities will be provided, as soon as a central location is selected.

According to Dr. Sutton the term veterans clinic is a misnomer. He believes that a more proper description for the service would be processing station since no treatment of any kind of hospitalization was provided locally.

NEW ASSOCIATION MEMBER

The Canadian Department of National Defense has been granted associate institutional membership in the American Hospital Association. Interest and action by Brigadier C. R. D. Farmer, director general of medical services for the dominion, led to negotiations which resulted in the membership.

Premature Nursery Opened at Hopkins

Opening of a premature baby nursery, described as the newest and most extensive facility of its kind in Maryland, was announced by Dr. Edwin L. Crosby, director of Johns Hopkins Hospital, on April 10.

Designed with the assistance of the Children's Bureau, U. S. Department of Labor, the modern nursery has controlled air conditions, special resuscitators and oxygen equipment, incubators, special food formulae and elaborate precautions against infection.

The 22-bassinet nursery, which cost in excess of $100,000 to build and equip, was completed through a combination of Johns Hopkins and Harriet Lane Home contributions, and a grant of more than $40,000 from the government under provisions of the Lanham Act.

Simultaneously with announcement of the nursery opening, Dr. Robert H. Riley, director of the State Department of Health, and Dr. Huntington Williams, commissioner of health for Baltimore, revealed completion of arrangements for emergency motor service with a portable incubator whereby premature infants outside the hospital can be rushed to the nursery immediately from any point in Baltimore or the state.

Catholic Nurses Meet

The National Council of Catholic Nurses will hold its third biennial convention May 24-28 in Toledo. Theme of the meeting, which will be attended by 1,000 delegates, is the Catholic nurse in a changing world.

Postwar Problems To Be Discussed at Western Conference

"The Hospital of Tomorrow" has been selected as the theme of the May 14-16 convention of the Association of Western Hospitals. Meetings will be held at the Biltmore Hotel, Los Angeles.

Future problems of the administrator have been divided into seven groups, and speakers will cover various aspects of each problem at the sessions. Main subjects are: Construction, public relations, personnel management, personal services to the patient, medical services, special services and meeting the cost of care.

The last session of the convention will be a panel discussion covering the unanswered questions of persons attending the meetings. Frank Walter, superintendent of Good Samaritan Hospital, Portland, and Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons will lead the discussion.

Some of the speakers who will appear on the program are: Ritz E. Heerman, president-elect of the association and superintendent of the California Hospital, Los Angeles; Dr. Anthony J. J. Rourke, physician superintendent of Stanford University Hospitals, San Francisco; James Hamilton, hospital consultant; E. I. Erickson, president of the American Protestant Hospital Association; Dr. Peter D. Ward, president of the American Hospital Association.

Also among the speakers are Dr. Otis Whitecotton, medical director of Alameda County Hospital, Oakland; C. Rufus Rorem, Ph.D., director of the Hospital Service Plan Commission, and George Bugbee, executive director of the American Hospital Association.

Sisters Plan Hospital

Dufferin House, Brantford, Ont., a former residence, has been taken over by the Sisters of St. Joseph of the Hamilton Diocese.

Following architectural and other surveys the residence will be converted into a hospital which will be directed by the order.

WHITEHALL NAMED ACTING DIRECTOR, JOHNSON ADDED TO BUREAU STAFF

The editorial staff of HOSPITALS has been enlarged through addition to the staff of Bremen I. Johnson, who will work with the Washington Service Bureau, of which Albert V. Whitehall has been acting director since April 15 when James Russell Clark left to become director of Brooklyn (N.Y.) Hospital. Mr. Whitehall also assumes the position of acting secretary of the Council on Government Relations.

Mr. Whitehall, a native of Ontario, Canada, joined the Association in June 1945 as staff attorney.

MR. WHITEHALL

MR. JOHNSON

Since September he has been stationed at the Washington Service Bureau where he is primarily concerned with state and federal legislation affecting hospitals.

A graduate of Kent College of Law, Chicago, Mr. Whitehall spent five years in the legal department of the Hearst newspapers in Chicago and more than eight years as staff attorney for the Chicago *Daily News* before coming to the Association.

Mr. Johnson, a graduate of Northwestern University where he was a premedical student, has had four years experience in writing for and editing newspapers. He has recently completed two years of naval service.

While in service Mr. Johnson was a pharmacist's mate in the Navy Hospital Corps and spent seven months in the Pacific aboard the hospital ship Tranquility. He received his discharge in December 1945. He is married and has one daughter.

It is expected that more Washington news coverage and general service, needed since the end of the war, will be possible through the addition of Mr. Johnson to the staff.

Architects' Roster Will Not Require Membership Status

Listing in the roster of approved hospital architects will be independent of Association membership under a new amendment to the policy governing the architects approval program.

This action, approved by a mail vote, April 11, was taken at the recommendation of the Committee on Hospital Architects Qualfications. The measure was adopted in accordance with a suggestion made by the executive committee of the American Institute of Architects.

The immediate purpose of lifting membership requirement is to remove a barrier to the rapid creation of the largest possible roster of qualified architects. Immediate concentration of this phase of the program is planned by the Council on Hospital Planning and Plant Operation, according to A. W. Snoke, M.D., chairman.

The amendment was unanimously recommended by the council and approved by the Coordinating Committee and Board of Trustees. Under its provisions, the membership of architects will still be limited to those hospital architects who demonstrate their knowledge of hospital requirements to the qualifications committee. Under it, all architects whose qualifications are favorably acted on will be listed in the roster regardless of their decision on applying for or maintaining membership.

As a means of keeping the list active, non-member approved architects will be required to pay an annual token registration fee of $1.00. Revised application blanks will shortly be available.

Recent action by the Hospital Architects Qualifications Committee approved eight new architects for the roster. With architects previously approved, the roster now includes 40 names.

Another amendment of the program has been made to clarify the Association's statement on the employment of qualified hospital architects in a consulting capacity. The statement now reads, "The American Hospital Association . . . will promote the general practice of engaging hospital architects of established qualifications for the design of hospitals or as consulting architects to supplement the services of architects lacking specialized knowledge of hospital requirements."

The policy elsewhere has been amended to read, "It is the basic intention of this program to create a roster naming the largest possible number of qualified hospital architects."

Dr. Lull New Head Of A.M.A. Staff; Dr. West Retires

Dr. Olin West, secretary-general manager of the American Medical Association, retired April 1 and has been succeeded by Dr. George F. Lull, former deputy surgeon general, U. S. Medical Corps, who has been assistant to Dr. West since the first of this year.

Joining the A.M.A. as field secretary in 1923, Dr. West spent 23 years as a member of the organization. Shortly after joining the association he became secretary and in 1924 assumed the duties of general manager.

Dr. West is a graduate of the Vanderbilt University School of Medicine where he was a member of the faculty for 15 years. He has been secretary and executive officer of the Tennessee state board of health and director for the Rockefeller Sanitary Commission and International Health Board in Tennessee.

Dr. Lull, who received his medical degree at Jefferson Medical College, graduated from Harvard University and the University of Pennsylvania. He enlisted in the Army Medical Corps in 1912 and retired with the rank of major general.

Drive Raises $302,000 Fund

Total contributions of $302,233 were reported at the close of a recent fund raising drive conducted by Mercy Hospital, Benton Harbor, Mich.

The money, plus $100,000 accumulated by the hospital over a period of years, will be used for construction of a 60-bed addition. Alterations and improvements of the present hospital building are also planned.

Tennessee Hospitals Are Asked to Help Placement Service

The board of trustees of the Tennessee Hospital Association is considering a request by the state nurses association for financial support for its placement and counselling service. The request was presented at the state association meeting held in Knoxville April 8.

According to the nurses' plan, contributions from member hospitals would be used to carry on an intensive drive for the recruitment of student nurses for hospitals in the state.

Included in the program of the meeting was a discussion of S. 191 and the state survey of hospital facilities. W. N. Walters, director of the survey, was elected association president.

Other officers are:

PRESIDENT-ELECT, T. H. Haynes, superintendent of Knoxville General Hospital; VICE-PRESIDENT, Sister Sponsoria, superintendent of St. Joseph Hospital, Memphis; SECRETARY-TREASURER, Henry H. Miller, superintendent of Hubbard Hospital, Nashville.

George W. Eutsler, Holston Valley Community Hospital, Kingsport, and Charlotte Lawson, R.N., Rutherford Hospital, Murfreesboro, trustees for one year; Charles E. Thompson, Willis C. Campbell Clinic, Memphis, and Mrs. Lois Beeby Stow, Protestant Hospital, Nashville, trustees for two years; George Sheats, Baptist Memorial Hospital, Memphis, and Walter Hilgers, Madison Sanatorium, trustees for three years.

Mr. Sheats was named two-year term delegate to the American Hospital Association and R. G. Ramsay of Gartley Ramsay Hospital, Memphis, alternate.

Annual Knudsen Award Is Conferred on Col. A. J. Lanza

The William S. Knudsen Award for the most significant contribution to the field of industrial medicine in the current year was presented to Col. Anthony J. Lanza, associate medical director of the Metropolitan Life Insurance Company, on April 11.

Colonel Lanza received the award, the seventh to be given, at the annual banquet of the American Association of Industrial Physicians and Surgeons.

CALENDAR OF ASSOCIATION AND ALLIED MEETINGS

American Hospital Association 48th Annual Convention—September 30-October 4; Philadelphia (Bellevue-Stratford and Benjamin Franklin Hotels).

Regional Association Meetings

American Protestant Hospital Association—September 27-28; Philadelphia.

Association of Western Hospitals—May 14-16; Los Angeles (Biltmore Hotel).

Carolinas-Virginias Conference—May 22-23; Greenville, S.C. (Poinsett Hotel).

Catholic Hospital Association—June 10-13; Milwaukee (Milwaukee Auditorium).

Maritime Hospital Association—June 18-21; Digby, Nova Scotia ("The Pines").

Tri-State Hospital Association—May 1-3; Chicago (Palmer House).

State Association Meetings

Arkansas—May 16-17; Little Rock (Albert Pike Hotel).

Idaho—December 7; Boise.

Illinois — May 1-3; Chicago (Palmer House).

Indiana — May 1-3; Chicago (Palmer House).

Kansas—November 13-14; Topeka (Hotel Jayhawk).

Louisiana—May 2-3; Washington-Youree, Shreveport.

Maine—June 21-22; Belgrade Lakes (Belgrade Hotel).

Maryland—District of Columbia—November 7-8.

Michigan—May 1-3; Chicago (Palmer House).

Minnesota—May 26-28; St. Paul.

Montana—October 21; Butte.

Nebraska—October 21-22; Lincoln (Hotel Cornhusker).

New Jersey—May 2-4; Atlantic City (Hotel Dennis).

New Mexico—May 24-25; Albuquerque (Hilton Hotel).

New York—June 10-12; New York City (Pennsylvania Hotel).

North Dakota—May 9-10; Grand Forks.

Oklahoma—November 21-22; Oklahoma City.

Oregon—May 22-23; Eugene (Osborne Hotel).

Utah—December 4.

West Virginia—May 21; Greenville, S.C.

Wyoming—July 19—Jackson.

Other Meetings of Interest

American College of Hospital Administrators—September 28-30; Philadelphia.

American College of Surgeons—September 9-13; New York City (Waldorf-Astoria).

American Dietetic Association—October 14-18; Cincinnati (Netherland Plaza Hotel).

American Medical Association—July 1-5; San Francisco (Sir Francis Drake Hotel and Civic Auditorium).

Association of Collegiate Schools of Nursing—September 19-20; University of Pittsburgh.

Interstate Post Graduate Medical Association of North America—October 15-18; Cleveland (Municipal Auditorium).

National Council of Catholic Nurses—May 24-26; Toledo, Ohio (Hotel Commodore Perry).

National Executive Housekeepers' Association—May 21-23; Atlantic City.

Streptomycin Distribution To Civilians Is Outlined

Distribution of limited supplies of streptomycin to civilians through the Committee on Themotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council, has been provided for in the allocation program recently established by the Civilian Production Administration.

All inquiries and requests for this drug are to be sent to Dr. Chester S. Keefer, Evans Memorial Hospital, 65 East Newton, Boston, Mass.

No commercial distribution of streptomycin is provided and producers will not supply the drug directly for civilian requests. Physicians have been asked not to submit requests if cases are susceptible to the action of the sulfonamides, penicillin and other therapeutic agents.

Advisory Board in Review Of Red Cross Health Work

A review of Red Cross activities in the health field was presented to the Advisory Board on Health Services of the American Red Cross at its first meeting, in Washington April 16.

Subcommittees are being appointed, one of which is to be the Subcommittee on Hospital Administration, under the chairmanship of Dr. Basil C. MacLean, medical director of Strong Memorial Hospital, Rochester.

Dr. Lewis H. Weed is chairman of the board. Among those attending the meeting were Dr. Charles F. Wilinsky, director of Beth Israel Hospital, Boston; Arthur J. Will, director of the Department of Charities, Los Angeles and George Bugbee.

NATIONAL HOSPITAL DAY IS OPPORTUNITY TO DEMONSTRATE SERVICES TO PUBLIC

National Hospital Day May 12 provides the individual community hospital an opportunity to demonstrate to the public its many services and to gain understanding for its major problems.

The suggestions offered by the Council on Public Relations are assisting participation by many hospitals in this campaign. Some ingenuity in local adaptation is required, since it is impossible to create an over-all plan which will be immediately suitable to each member of the Association.

Using the council's suggestions as a guide, many hospital administrators and public relations directors are developing programs which reflect the spirit and objectives of their own individual hospital. The cooperation of interested citizens of the community is making a unified program possible—one that will strike a sympathetic note within the community.

Any of the three Hospital Day themes — "The Hospital, Your Hope for Health," in particular, as well as "Your Helping Hand" and "Building for Better Americans"—offers possibilities for indicating the contributions of the hospital to the community and to the nation.

Among hospitals' general contributions being cited are the inauguration of state hospital surveys, licensing systems, increased availability of prepaid hospital insurance, the trend toward establishment of health centers and medical insurance, the two-billion-dollar construction program that will add 180,000 non-federal hospital beds to those already in existence. All of these aim at the unified goal of all hospitals—adequate hospital care, easily available to all.

Hospital Day will also be the vehicle for explaining to the community that the war is not over for hospitals; that many of their war-created problems are as serious today as a year ago.

Many administrators will take advantage of the opportunity to explain to the public why hospitals are experiencing personnel shortages, both professional and otherwise; how increase in operating expenses, like all costs, is making it necessary to raise patient rates in some hospitals, despite administrative reluctance; why hospitals cannot always accommodate every patient who seeks admittance; why delays of weeks are sometimes necessary and why patients must often be treated under crowded conditions.

They will demonstrate to their communities why plans for new construction or additions to old cannot be immediately put into effect, and why volunteers are needed now as badly as at any time during the war.

These, as well as any particular problem which concerns the relationship between the individual hospital and its community, will reach a more receptive audience on Hospital Day.

Many real and potential causes of public friction can be explained in this way and used to secure community assistance. An enlightened and understanding public is the hospital's best ally, and such a public will be quick to protect the hospital's interests—actually they are their own. More than ever before, hospitals need the understanding cooperation of the public—their individual community.

There may still be time to take advantage of the campaign ideas and publicity material offered in the kit prepared by the Council on Public Relations. Further aids to participation are the National Hospital Day Stamp and the booklet, "The Hospital—Your Hope for Health," suitable for general distribution.

Alexian Brothers' Nursing Courses Open to Veterans

Application of the G. I. Bill of Rights to provide tuition for a course in nursing has been approved by the Alexian Brothers' Hospital, Chicago. Fifteen veterans are enrolled currently in the school of nursing under the program.

Alexian Brothers' nursing school, open to male students only, is conducted in cooperation with De Paul University, Chicago. Veterans with the proper qualifications can enroll in a four-year course which awards both the R.N. and university degree.

Students who are not qualified for college entrance may enroll in the basic three-year nursing course which leads to the R.N. certificate.

Delegates Discuss Nursing Problems At Texas Meeting

The relationship of the graduate nurse to other grades of nursing personnel and general nursing problems were discussed at the March 21-23 meeting of the Texas Hospital Association at Forth Worth.

Delegates heard a report on a recent state Supreme Court decision which seemed to indicate that

MR. TERRELL

MR. NYE

hospitals paying professional staff members on a percentage basis might lose their nonprofit institution classification.

Other subjects discussed included veterans' care, personnel problems, hospital retirement plans, Blue Cross payments to hospitals and affiliation with the American College of Hospital Administrators.

B. Tol Terrell, administrator of Harris Memorial Methodist Hospital, Fort Worth, was inducted as president. Officers elected were:

PRESIDENT-ELECT, Russell Nye, administrator of the City County Hospital System, Dallas; FIRST VICE-PRESIDENT, Mother Regina, administrator of Mother Francis Hospital, Tyler; SECOND VICE-PRESIDENT, J. H. Felton, business manager of Lubbock Memorial Hospital; THIRD VICE-PRESIDENT, D. S. Riley, administrator of Malone and Hogan Hospital, Big Spring; TREASURER, Oswald Daughety, administrator of Hermann Hospital, Houston.

TRUSTEES: William Bohman, administrator of John Sealy Hospital, Galveston and George Buis, administrator of Brackenridge Hospital, Austin, both for three-year terms.

Russell Nye, administrator of City County Hospital System, Dallas, and Mrs. Josie M. Roberts, administrator of Methodist Hospital, Houston, were elected delegates to the American Hospital Association. First alternate is Julian Pace, administrator of Hillcrest Memorial Hospital, Waco, and second alternate is Eva M. Wallace, administrator of All Saints Hospital, Fort Worth.

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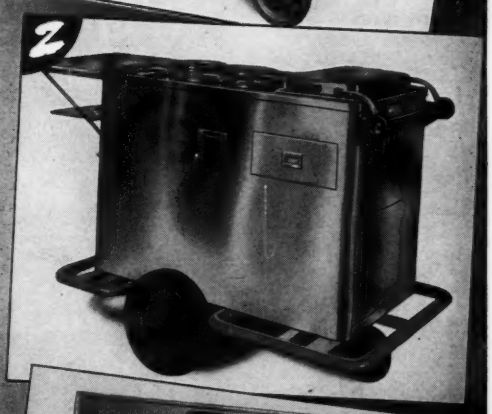

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NEW COMMITTEE ANNOUNCES PLANS FOR INSTITUTE ON PERSONNEL MANAGEMENT

Five aspects of personnel administration will be covered at the institute in hospital personnel management which will be held July 29 through August 2, at the Drake Hotel, Chicago. The institute will be directed by James W. Stephan, chairman of the Personnel Committee.

Subjects around which the institute will be centered are: (1) relations with employee groups, (2) recruitment selection and upgrading, (3) personnel administrative functioning, (4) administrative aspects of supervisory training, (5) salary theory with applications to the hospital field.

Faculty for the institute will include persons inside the hospital field and recognized authorities outside the field.

It is expected that the institute will be sponsored by the Industrial Relations Center of the University of Chicago which is directed by Fred Harbison, a member of the newly formed Institute executive Committee of the Council on Administrative Practice which is planning the institute. Other committee members include Mr. Stephan, Charles Prall, Nellie Gorgas, Marion Pierce, Norman D. Bailey, Dr. Arthur C. Bachmeyer and George Bugbee. Kenneth Williamson, secretary of the Council on Administrative Practice, is committee secretary.

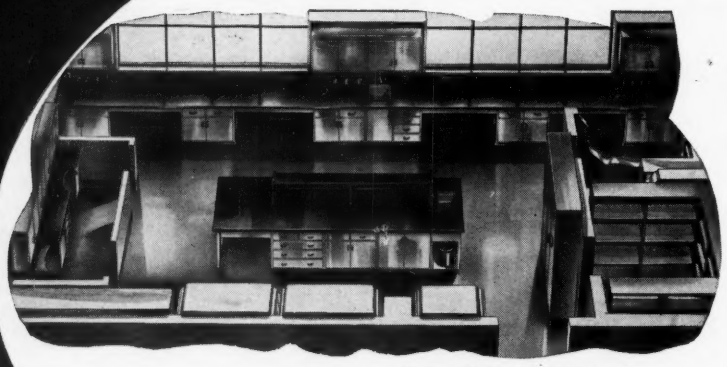
A maximum registration of 125 persons has been set. Applications for registration will be restricted to administrators, assistant administrators and personnel officers. Applicants must be personal members, or be employed by hospitals holding institutional membership in the Association.

Fee for the institute will be $25; each registrant will be responsible for his living expenses. Applications may be secured by writing to the Council on Administrative Practice, 18 E. Division St., Chicago 10. After they have been received the applications should be completed and returned to headquarters with a check to cover the institute fee.

Tentative plans also have been announced for a personnel institute to be held on the West Coast, probably in August. Details of applications, enrollment date and place will be announced in the next issue of HOSPITALS.

Sheldon

HOSPITAL EQUIPMENT



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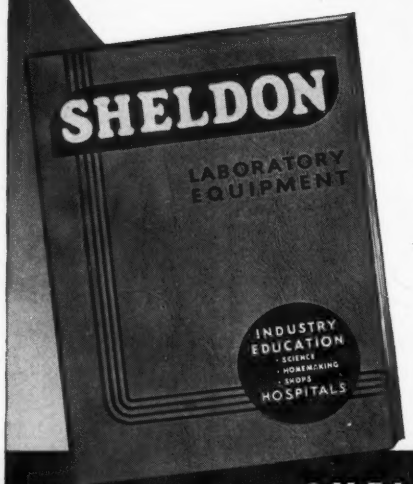

Write for SHELDON'S new catalog of Hospital Fixed Equipment — a catalog showing complete Hospital Equipment and plans for functional rooms.

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A.M.A. Medical Care Plan Granted Corporate Charter

A further step in establishing a nationwide organization of medical care plans was announced in the April 13 issue of the *Journal of the American Medical Association:* the state of Illinois has now granted a certificate of incorporation to Associated Medical Care Plans.

At the same time it was announced that the commission (corresponding to a board of directors) would meet April 26-27 to draw up operational details which will be submitted to members of the new corporation at the time of the American Medical Association convention in July.

Paying for Itself...

IN THOUSANDS OF DISHWASHING DEPARTMENTS EVERYWHERE

Like an efficiency expert, Salvajor is going into the busy kitchens of America checking waste time, labor and money, improving and speeding up dishwashing wherever it is employed.

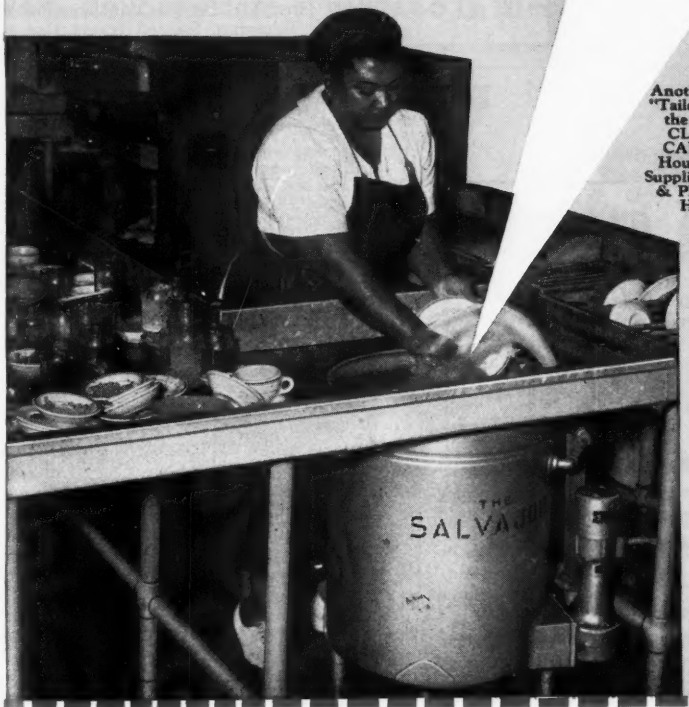
One Salvajor feature alone, the tableware trap, soon pays back the original investment. In most institutions the loss of silverware ordinarily adds up to 4% a month —complete loss every 2 years!

Then there are other practically immeasurable savings. Help is happier because hand-scrapping and all its smell and mess is eliminated. In one unique operation Salvajor Pre-Rinses dishes, sanitizes and reduces garbage volume by 40%, in addition to trapping the silverware.

With Salvajor, dishes enter the dishwashing machine cleaner, making detergent more effective and eliminating bottleneck shut-downs of the dishwashing machine to clean screens and change water.

For all-around efficiency, Salvajor is doing a job people like!

Salvajor is not to be confused with a dishwashing machine nor does it grind garbage.



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- **Economical to Operate**
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Only 2 gallons of fresh water per minute is used. A fractional horsepower motor is used for the recirculation of 20 gallons per minute during operating periods.

No special training is needed to operate the Salvajor. One operator using the Salvajor can scrap as much tableware as 3 or 4 helpers by ordinary hand scrapping.

For further details contact your supplier or send the coupon.

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BENEFIT RECOMMENDATIONS FOR NURSES APPROVED BY WASHINGTON STATE GROUP

A list of recommendations for discussing nurses' salaries and working conditions has been submitted to member hospitals by the Washington State Hospital Association. These recommendations were developed at the association's convention in Tacoma March 14-15.

It was suggested that minimum salary rates be established locally, because of varying conditions throughout the state, but that differentials for evening and night duty be $10 and $5 respectively.

Some other points included in the recommendations were keeping the basic work week at 48-hours, compensation for overtime at straight time rate, recognition of six holidays during the year, allowance of one day of sick leave a month for nurses who have been in a position six months or more and an annual vacation of 12 working days based on one day for each month.

The recommendations also included encouragement of membership in the American Nurses Association and allied professional organizations, a suggestion that the state nurses' group be notified that administrators, realizing that nurses have a problem and that future negotiations probably will occur, recommend nurses make contact with local hospitals through their district association in the future.

Nan Rowlands, R.N., administrator of Cobb Hospital, Seattle, was elected president of the association. For her distinguished service, Sister John Gabriel of Mount St. Vincent Hospital, Seattle, was chosen as life honorary president.

Other officers elected were:

PRESIDENT-ELECT, Dr. Burton A. Brown, administrator of Pierce County Hospital, Tacoma; SECRETAY-TREASURER, A. L. Holberg, business manager of Maynard Hospital, Seattle; EXECUTIVE SECRETARY, Jewell Drake, R.N., Cobb Hospital, Seattle; FIRST VICE-PRESIDENT, Mrs. Cecile Tray Spry, R.N., administrator of Everett General Hospital; SECOND VICE-PRESIDENT, Sister Brendan, Sacred Heart Hospital, Spokane; THIRD VICE-PRESIDENT, Horance Turner, administrator of Deaconess Hospital, Spokane.

Ethel V. Soper, R.N., hospital relations advisor to the Seattle Blue Cross Plan; Mrs. Gertrude Sawyer, superintendent of Memoral Hospital, Sedro-Woolley, trustees for one year. Howard C. Ries, a trustee of Everett General Hospital; Gordon W. Gilbert, administrator of St. Luke's Hospital, Spokane, trustees for two years. A. L. Howarth, administrator of Deaconess Hospital, Wenatchee; Walter A. Heath, director of Tacoma General Hospital, trustees for three years.

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Hospitals that install Vestal Septisol Dispensers and Septisol Surgical Soap, never go back to less efficient scrub-up technique.

Doctors are enthusiastic about the foot operated convenience and sanitary features of the Septisol dispenser . . . and Septisol Soap is "just what the doctor ordered" . . . a scientifically blended surgical soap that lathers to a smooth, creamy richness conditioning the hands and preventing danger of infection and roughness that result from harsh, irritating soaps.

. . . and Management smiles at the soap economy and all-round satisfaction that follows Septisol installation. Write for demonstration TODAY.

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Refresher Course Offered For Hospital Dietitians

A six-week refresher course for hospital dietitians will be held at Teacher's College, Columbia University, from July 8 through August 16.

Designed primarily to serve as a center for discussion of developments in the field, the course will cover observation and experience in the management of food services.

The course is open to dietitians whose training and experience are satisfactory to the instructors. Application must be made before May 15-to Mary deGarmo Bryan, Teacher's College, Columbia University, New York City. Fees, including registration, total $82.

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For Blood, Parenteral Fluids, Blood, Etc.
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Muel-Tex Tubing is inner surface sealed for safety. It is dust-free, manufactured by a method in which the inner surface is never exposed to air or dust of any kind. An inner protecting seal of cocoanut oil soap protects this inner surface from air borne contamination until the final washing and sterilization before use . . .

Muel-Tex Tubing is seamless. Its perfectly smooth inside wall has no pits, cracks or crevices to complicate thorough cleansing. Muel-Tex gives you longer service life, too: it withstands many sterilizations . . .

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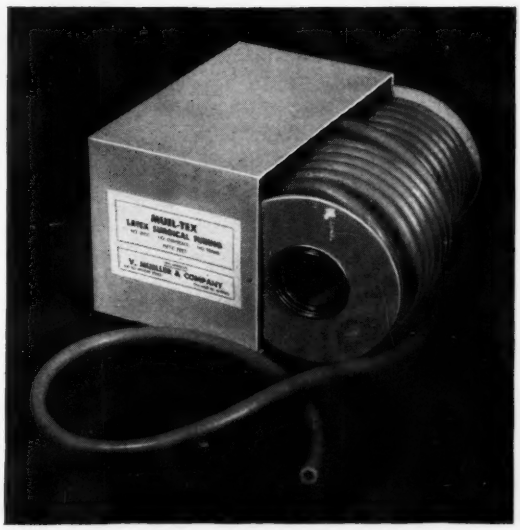

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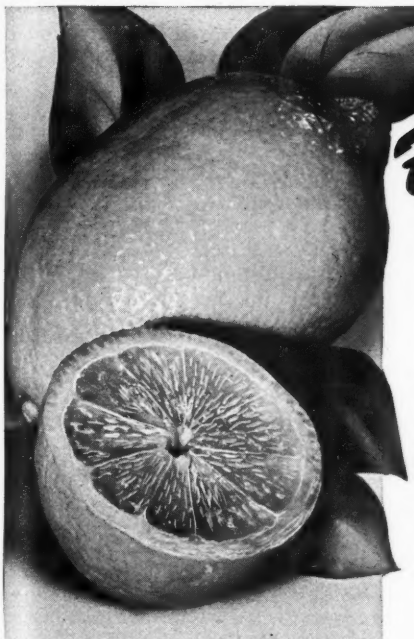

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IOWA ASSOCIATION APPROVES PERSONNEL PRACTICE PLAN OF STATE NURSE BODY

The Iowa State Hospital Association adopted a resolution approving in principle the personnel practice plan introduced by the state nurses' association at the state hospital association meeting April 15-17 in Des Moines.

While calling attention to the fact that the state association could not bind its members to agreement of following practices outlined in the plan, the association returned the plan to the nurses for some revision. It was suggested that an explanation of the public responsibilities of nursing organizations in the care of patients be included in the statement.

Another resolution passed at the meeting authorized the association's board of trustees to investigate and negotiate with the Veterans Administration toward establishment of a plan for the use of one agency for payments of all veteran care.

Dr. C. F. Oberman, superintendent of Cherokee State Hospital, was elected association president. Other officers are:

PRESIDENT-ELECT, Paul Hanson of Iowa Lutheran Hospital, Des Moines; FIRST VICE-PRESIDENT, Sister Mary de Lellis, R.N., administrator of Mercy Hospital, Oelwein; SECOND VICE-PRESIDENT, Harold A. Smith, assistant administrator of University of Iowa Hospitals, Iowa City; SECRETARY, Clara Hendrickson, superintendent of Iowa Lutheran Hospital, Des Moines; TREASURER, Lilyan C. Zindell, administrator of Atlantic Hospital.

TRUSTEES: Rubie M. Carlson, R.N., superintendent of Allen Memorial Hospital, Waterloo; T. P. Sharpnack, administrator of Broadlawns Polk County Hospital, Des Moines.

Miss Carlson was named delegate to the American Hospital Association and Mr. Sharpnack, alternate.

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Controlled Temperature at Minimum of 38° F Prevents Freezing

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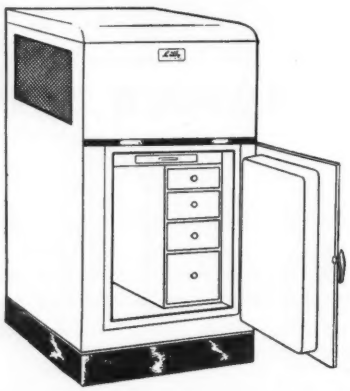
The temperature of interior is controlled at a minimum of 38° F, thus preventing freezing. Temperature above 38°F can be obtained by adjusting thermostat.



SPECIFICATIONS

External overall dimensions, 35″ high x 19½″ wide x 18⅛″ deep.

Internal refrigerator space, including drawer assemble, 15″ high x 12″ wide x 12″ deep.

4 drawers—Storage space—Ice cube tray.

Alternating current—115 volts.

Weight 75 pounds. Warranty, one year against defective workmanship and material.

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C. J. Foley Takes Position on Staff Of Public Relations

C. J. Foley, former lieutenant in the United States Navy and son of the late Matthew O. Foley, National Hospital Day founder, joined the headquarters staff in April as a member of the Association's public relations department. Mr. Foley, who served for three years on a minesweeper in the Mediterranean and Caribbean, was separated from service last October. Prior to his entrance into the Navy, he was public relations director for the Wisconsin Hospital Association and the Associated Hospital Service, Milwaukee. From 1940 to 1942 he was associate editor of *Hospital Management*. Earlier he had served for three years as public relations director for Group Hospital Service Inc., St. Louis.

Mr. Foley

Mr. Foley comes to his Association position from Vaughan Hospital, Hines, Ill., where he was employed as public relations director from January to April of this year. He holds a Bachelor of Science degree from the University of Illinois.

FIRST IMPRESSION vs. FINAL JUDGMENT

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The administrator of a hospital who specifies FABRON may do so with the confidence that he is using a material that permanently decorates the wall — that is as durable as the wall itself.

He will know that the sturdy FABRON fabric and plastic backing gives strength to walls, preventing cracks and concealing blemishes, while its decorative lacquer surface creates a restful and homelike atmosphere. Furthermore, FABRON can be washed simply and easily with soap and water, thereby removing dust and grime and restoring the original beauty of the colors, eliminating the need for periodic redecoration.

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Norton Medical Writing Contest to Close in Fall

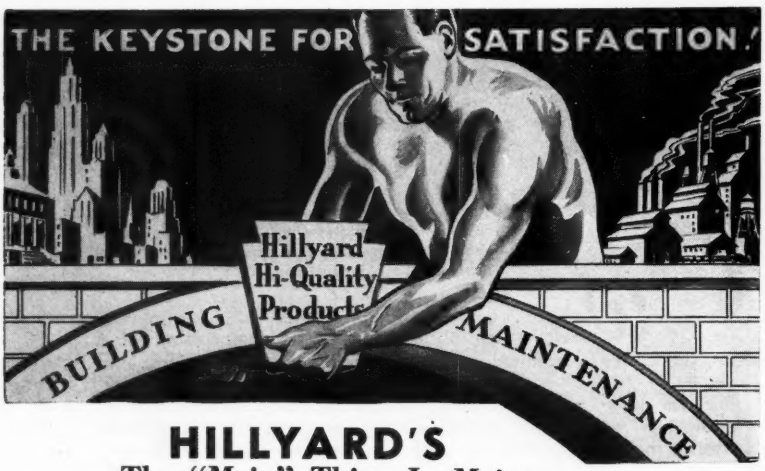
The Norton Medical Award contest, designed to encourage the writing of books on medicine and the medical profession for the layman, has announced November 1 as the closing date for the 1946 competition.

Further information may be obtained by writing to North and Company, 70 Fifth Avenue, New York City 11.

Research Expansion Planned

Dr. Stephen Manheimer, director of Mount Sinai Hospital, Chicago, has announced a $150,000 pledge from the hospital's service club, an auxiliary group.

The money will be used for support of research in the hospital's expanded research program which includes erection of a new professional services building to house the laboratories, x-ray department, research activities and other similar facilities.



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Health Group Adds Committee Members

The American Public Health Association is preparing to work out the details of its national health program which was first announced in October 1944.

To this end the Subcommittee on Medical Care has been expanded, and a full time staff will work under a Rockefeller Foundant grant. Howard M. Kline, Ph.D., of the Federal Security Agency, has been named technical secretary.

The committee as it now stands includes:

CHAIRMAN: Dr. Joseph W. Mountain, chief of the States Relations Division, USPHS; Dr. Dean A. Clark, medical director of the Health Insurance Plan of Greater New York; Dr. Edwin F. Daily, director of Health Services, U. S. Children's Bureau; Isidore S. Falk, Ph.D., director of the Bureau of Research and Statistics, Social Security Board.

Dr. Vlado A. Getting, Massachusetts State Commissioner of Public Health; Dr. J. Roy Hege, director of the Division of Local Health Administration for the North Carolina State Board of Health; Dr. Basil MacLean, superintendent of Strong Memorial Hospital, Rochester, N. Y.

Dr. Hugh Morgan, professor of medicine at Vanderbilt University School of Medicine; George St. John Perrot, chief of the Division of Public Health Methods, USPHS; Marian G. Randall, R.N., executive director of the Visiting Nurse Service of New York; Dr. Dean Roberts, chief of the Bureau of Child Hygiene, Maryland State Health Department.

Dr. Edward S. Rogers, assistant commissioner of the New York State Department of Health; Nathan Sinai, Dr.P.H., professor of public health at the University of Michigan; R. M. Walls, D.D.S., Bethlehem, Pa., Dr. John B. Grant and Dr. Hugh R. Leavell, consultants for the Rockefeller Foundation.

Mahoning County, Ohio, in Mass X-Ray Survey Program

A mass x-ray survey program for tuberculosis was begun recently in Mahoning County, Ohio. The project is expected to develop into annual x-ray examinations for every child and adult in the county, which includes Youngstown and 13 suburban communities.

Infected persons will be instructed to see either their family physician or a county medical society physician. Those unable to afford treatment will be cared for by medical personnel at Mahoning Sanitarium.

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Outline of Final Report on Hospital Survey Approved

A detailed outline of a forthcoming comprehensive report by the Commission on Hospital Care was approved at a meeting of the commission April 4 and 5 in Philadelphia.

To be presented publicly at the American Hospital Association convention in the fall, the report will be organized in several sections. Influence and trends in administrative relationships and patterns or organization underlying future developments of hospital service will be discussed in detail, physical service and financial aspects of existing hospitals will be analyzed and estimates for additional facilities based on factors affecting size, use and location of hospitals necessary to serve the public needs adequately will be made.

The report will carry suggestions for greater integration of hospital service. Also included will be background material on the historical development of hospitals, methods of financing care, legal status of hospitals and interrelationships of hospitals with voluntary and governmental agencies. It is expected that the report will be ready for printing about October 1, and completed for distribution on January 1.

A method for estimating hospital bed need, based on deaths in hospitals, was presented at the meeting and approved as a means for estimating facilities necessary to serve the public need more adequately. Commission members analyzed and drafted recommendations concerning policy problems on various aspects of hospital administration and methods, and discussed ways for financing hospital care.

Dr. A. C. Bachmeyer, director of study for the commission, reported that 36 states now are in the process of making detailed hospital studies according to the method of survey outlined by the commission.

New Building Planned

The Stratford General Hospital Trust has announced plans for erection of a new building to relieve congestion in the Stratford (Ont.) General Hospital.

CURRENT LISTING OF NEW MEMBERS

INSTITUTIONAL MEMBERS

CALIFORNIA

Lynwood—St. Francis Hospital
Van Nuys—Valley Hospital of Van Nuys

DELAWARE

Dover—Kent General Hospital, Inc.

DISTRICT OF COLUMBIA

Washington, D. C.—Episcopal Eye, Ear, and Throat Hospital

IDAHO

Wendell—St. Valentine's Hospital

ILLINOIS

Chicago—Chicago Intensive Treatment Center
Chicago—Salvation Army Booth Memorial Hospital

IOWA

Estherville—Holy Family Hospital

KENTUCKY

Harlan—Harlan Hospital Association

NEBRASKA

North Platte—North Platte Memorial Hospital

NEW MEXICO

Embudo—Embudo Presbyterian Hospital

NEW YORK

Westfield—Westfield Memorial Hospital

PENNSYLVANIA

Altoona—Altoona Hospital
Broomall—Rest Haven for Convalescents
Pittsburgh—St. John's General Hospital

TENNESSEE

Oakville—Oakville Memorial Sanatorium

WASHINGTON

Snoqualmie Falls — Snoqualmie Falls Hospital
Vancouver—St. Joseph Hospital

WEST VIRGINIA

South Charleston—Herbert J. Thomas Memorial Hospital

HAWAII

Honolulu—Shriners' Hospitals for Crippled Children

FOREIGN

Caracas, Venezuela—Centro Medico
Madrid, Spain—Caja Nacional de Seguro de Enfermedad
Bombay, India—Sir Hurkisondas Nurrotamdas Hospital

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Abbott, Doris A., R.N., Supt. Redington Mem. Hosp., Skowhegan, Maine
Anderson, Gordon, Trustee, Miles Mem. Hosp., Damariscotta, Maine
Beck, Paul R., Trustee, Butler Co. Mem. Hosp., Butler, Pa.
Boncampagne, Madam Margaret, Trustee, Mt. Desert Island Hosp., Bar Harbor, Maine
Bone, James H., Asst. Dir. Clinics, Univ. of Ill. Hosps., Chicago
Bork, Ralph George, Bus. Mgr., St. Mary's Hosp., Evansville, Ind.
Brown, Norah E., Dir. of Nrs., Heaton Hosp., Montpelier, Vt.
Brunelle, Sister, Acting Supt., Fanny Allen Hosp., Winooski, Vt.
Byrd, J. C., Asst. Admin., S. Baptist Hosp., New Orleans, La.
Callahan, Mary, Supt., Wentworth Hosp., Dover, N. H.
Cates, Fred Wm., Auditor, St. Luke's Hosp., St. Louis
Chapman, E. J., M.D., Vice-Pres., Greenville Hosp., Jersey City, N. J.
Cheeva, Rev. George, Trustee, Miles Mem. Hosp., Damariscotta, Maine
Chittick, R. A., M.D., Supt., Vermont State Hosp., Waterbury, Vt.
Clark, L. O., M.D., Pres., Lafayette (La.) Sanitorium
Cole, Paul Murphy, Student, 1445 E. 67th St., Chicago
Coppinger, H., M.D., Supt., Winnipeg (Can.) General Hospital
Dane, Mrs. Eunice, Trustee, Mt. Desert Island Hosp., Bar Harbor, Maine
De la Camara, Dr. J. P., Supt., Caja Nacional de Seguro de Enfermedad, Madrid, Spain
De la Quintana, Dr. P., Sub-Dir., Caja Nacional de Seguro de Enfermedad, Madrid, Spain
Dirigeau, Mrs. Hertha, Night Superv., Greenville Hosp., Jersey City, N. J.
Dodge, L. A., Trustee, Miles Mem. Hosp., Damariscotta, Maine
Dow, Harry A., Asst. Supt., Home for Incurables, Bronx, N. Y.
Dunton, Lucy A., Supt., St. Albans (Vt.) Hospital
Fagan, Lawrence A., Supt., Hartford (Conn.) Mun. Hospital
Ferry, Mary M., R.N., Supt., Heaton Hosp., Montpelier, Vt.
Finke, Charles H., M.D., Pres., Greenville Hosp., Jersey City, N. J.
Fisk, E. F. C., Asst. Admin., C. W. Long Mem. Hosp., Atlanta, Ga.
Fox, James C., Jr., Asst. Med. Supt., Hartford (Conn.) Hospital
Gallagher, Judge Ralph, Trustee, Miles Mem. Hosp., Damariscotta, Maine
Haythorn, Frank C., Bus. Mgr., Healthwin Hosp., South Bend, Ind.
Hocking, Richard R., Admin. Intern, Evanston (Ill.) Hospital
Huntly, Mabel F., Dir. Sch. of Nrs., M. Fletcher Hosp., Burlington, Vt.
Huston, G., Trustee, Miles Mem. Hosp., Damariscotta, Maine
Kellett, Major Thomas R., Dir., The Oswego (N. Y.) Hospital
King, John M., Admin., Newark (Ohio) Hospital
Kurtz, George S., Trustee, Butler (Pa.) Co. Hospital
Lamer, Wesby G., Supt. Coffey Memorial Hosp., Portland, Ore.
Lewis, B. I., R.N., Supt. of Nrs., Memorial Hosp. Brattleboro, Vt.
Littauer, David, M.D., Med. Dir., Menorah Hosp., Kansas City, Mo.
Lopez, Eugene, Asst. Admin., Univ. of Ill. Hosps., Chicago
Mack, John P., Vice-Pres., American City Bureau, Chicago
Marks, Mrs. K. B., Dir., Outpatient Dept., St. Joseph's Inf., Atlanta, Ga.
Masterman, Ralph C., Trustee, Mt. Desert Island Hosp., Bar Harbor, Maine
McCann, Mary T., Hosp., Inspector, St. Dept. of Health, Boston
McCarren, C. R., Trustee, Butler (Pa.) Co. Hospital
McCoy, Lois D., Pers. Dir., Mass. Gen. Hosp., Boston
McCully, Hertha, Hskp. Dir., Shadyside Hosp., Pittsburgh
Mildred, Sister M., Supt., Our Lady of Lourdes Hosp., Pasco, Wash.
Miles, Mrs. I. R., Pres., Miles Mem. Hosp., Damariscotta, Maine
Montgomery, W. T., Treas., St. T. B. Sanatorium, Alto, Ga.
Morris, Mrs. Mary A., Supt., Miles Mem. Hosp., Damariscotta, Maine
Mulford, John, Corporator, Woman's Med. College, Philadelphia
Nixon, Simeon, Treas., Butler (Pa.) Co. Hospital
Parker, George L., M.D., Supt., Pondville Hospital, Norfolk, Mass.
Patrice, Sister Mary, Dir. of Nrs., St. Joseph's Inf., Atlanta, Ga.
Payne, Lawrence, Admin., Baylor Univ. Hosp., Dallas, Texas
Pierce, L. R. Vice-Pres., Miles Mem. Hosp., Damariscotta, Maine
Power, Katheryn H., Pub. Rel. Dir., Shadyside Hosp., Pittsburgh
Ritts, Elias, Pres., Butler (Pa.) Co. Hospital
Rose de Lima, Sister M., Trustee, St. Joseph's Inf., Atlanta, Ga.
Rudolph, Charles W., M.D., Supt., Hosp. for the T.B., Kearney, Nebr.
Rudovick, S. Anna, Asst. Secr., Somerset Hosp., Somerville, N. J.
Sangani, P. R., M.D., Supt., Sir Hurkisondas Hosp., Bombay, India
Sherburne, John C., Trustee, Gifford Mem. Hosp., Randolph, Vt.
Sherrill, Mrs. A. C., Admin., Citizens Hospital, Barberton, Ohio
Smith, Mrs. Lois E., Secr. to Supt., St. Joseph's Inf., Atlanta, Ga.
Starks, Lloyd W., Controller, Middlesex Hosp., Middletown, Conn.
Stetson, Marion, Trustee, Miles Mem. Hosp., Damariscotta, Maine
Tubergen, Harry F. Admin., Bethany Hosp., Kansas City, Mo.
Walker, Mildred, Consultant, Children's Bureau, Washington, D. C.
Whaley, Louise R., Exec.-Housekeeper, Mt. Sinai Hospital, Baltimore, Md.

SURVEY SHOWS NEED OF RECRUITING BOTH GRADUATE AND STUDENT NURSES

Intensive recruitment of student nurses is still considered necessary if schools are to keep pace with the increasing demand for nursing personnel.

A recent survey by the Council on Professional Practice fixes the classroom need at 43,000. This corresponds with the goal of 40,000 students for fall classes set by the Committee on Careers in Nursing —formerly the National Nurse Recruitment Committee—of the National Nursing Council.

Hospitals with schools of nursing anticipate difficulty in filling class quotas, according to survey figures. More than 70 per cent of the fall classes are still unfilled, with 70 per cent of the schools expecting difficulty in filling them.

Analysis of 965 of the questionnaires in April showed that 87 per cent of the hospitals reporting would employ more nurses at this time. Compared to a similar survey last October, 32 per cent of the hospitals acutely short then are more seriously in need of nurses now. Thirty per cent of the group are less in need of nursing personnel currently.

MEN AND WOMEN: The Committee on Careers, meeting in New York City April 1 and 2, agreed on a list of six purposes in an effort to stimulate recruitment of men and women students.

In presenting the purposes the committee declared that while planning of long range problems was part of its duty the immediate future calls for dealing with an emergency situation caused by the continuing nurse shortages in many areas.

Purposes listed by the committee are: To enroll 40,000 new students in basic professional courses during the school year beginning July 1; to enroll graduate nurses in advanced professional courses; to enroll students in approved practical nurse courses; to stimulate the interest of college students in nursing as a career; to help the public understand that improvement in nursing educational programs brings improvements in nursing service; to encourage nonprofessional participation in enrollment activities.

The committee, which elected Edith H. Smith, dean of the Syracuse University School of Nursing, as its chairman, indicated its approval of radio publicity directed at student recruitment.

MORE RADIO: A desire for such publicity was expressed by hospitals answering the questionnaire distributed by the Council on Professional Practice. A "Help for Hospitals" national radio publicity campaign, emphasizing student recruitment, was requested by 78 per cent of the hospitals with schools of nursing. About half of all hospitals reporting asked for a campaign for graduate nurses.

Because of the definite need shown for such a campaign the Advertising Council has allocated the week of May 6 to a "Help for Hospitals" drive devoted to student recruitment. The campaign, which reaches an estimated 75,000,000 radio listeners, is sponsored jointly by the Advertising Council and the U. S. Public Health Service.

Plans for supplementing the national radio time with local programs where needed are being worked out by the Committee on Careers in Nursing.

As a further aid in publicizing the need for student nurses, the Nursing Information Bureau, which is represented on the Committee on Careers, is preparing a leaflet on basic professional nursing which should be available early this month. The leaflet will be supplemented by a new edition of the bureau's pamphlet, "Educational Funds."

BLUE CROSS PASSES 21,000,000 MARK

C. Rufus Rorem, director of the Commission on Hospital Care, announced an enrollment of 21,500-000 Blue Cross members nationally when he testified at a Senate Labor Committee hearing on the Murray-Wagner-Dingell Bill April 22.

This figure represents the largest quarterly enrollment in Blue Cross history, Dr. Rorem said. First quarter gains, as of April 1, were 1,370,-053 members.

Problem Discussion Held By Indiana Administrators

A discussion of institutional problems was held recently by more than 100 Indiana hospital administrators. Under the sponsorship of the state association, the meeting, held in Indianapolis, was led by Sister Mary Reginald, R.N., administrator of Mount Mercy Sanitarium, Dyer, who is the association president.

New England Assembly Officers Confer

RECENTLY ELECTED officers of the New England Hospital Assembly discuss the assembly's printed convention program, held by Donald S. Smith, president. In the group are Paul J. Spencer, secretary, Mr. Smith, Rev. Donald A. McGowan, vice president and Lester E. Richwagen, treasurer. They were elected at a meeting in Boston March 11-13.

STATISTICS ON HOSPITALS REPORTED BY AMERICAN MEDICAL ASSOCIATION

Nongovernmental hospital admissions rose 366,661 from 1944 to 1945, according to the American Medical Association annual survey of hospital service, reported in the *Journal* for April 20. For 1945 the total was 9,858,289; for 1944 it was 9,491,628.

Governmental hospital admissions, on the other hand, dropped 146,107—from 6,545,220 to 6,399,113. Bed capacity in nongovernmental hospitals was 382,226 for 1945, an increase of 4,559. Governmental hospitals follow the same trend with a 4,440 increase. Governmental hospitals list 1,356,718 beds in 1945 and 1,352,278 in 1944.

Net increase in 1945 bed capacity was 8,999. This is below the annual average (1909-1940) of 26,000, and far below such wartime increases as 80,691 for 1944 and 265,427 for 1943.

The greatest rise in bed capacity is reported by general hospitals in the nongovernmental group. Figures rose from 314,814 to 321,283. General hospitals provide 53 per cent of all beds in nongovernmental service.

▶ Nongovernmental hospitals show a slight but steady increase in occupancy over the last three years. In 1945 occupancy was 76 per cent; in 1944 it was 75 per cent; in 1943 it was 72.7.

Governmental occupancy figures show a rise over the 1944 percentage, but still do not reach the 1943 figure of 84.5 per cent. In 1945 it was 82.1 per cent; in 1944 it was 75.1.

▶ Average length of stay in all nonprofit general hospitals has remained the same for the last three years—9.8 days.

In governmental general hospitals the length of stay was 26.2 days, as compared to 20.3 days in 1944 and 29.0 days in 1943.

▶ Schools of nursing reported a student enrollment of 130,909 for 1945. This figure is slightly higher than the 1944 enrollment of 129,879, and represents an increase of 19,657 over the 1943 enrollment of 110,222.

There were 1,250 accredited schools of nursing listed for 1945. Although the number of students has risen, the number of schools has dropped since 1944 when a figure of 1,435 was reported. The 1945 figure also is lower than the 1,411 schools listed for 1943.

SUMMARY OF HOSPITAL DATA 1944-1945

All Registered Hospitals	*1944*	*1945*
Number	6,611	6,511
Bed Capacity	1,729,945	1,738,944
Bassinets	80,791	83,131
Patients Admitted	16,036,848	16,257,402
Births	1,919,976	1,969,667
Average Daily Census	1,299,474	1,405,247
Patient Days	475,607,484	512,915,155
General Hospitals		
Number	4,833	4,744
Bed Capacity	925,818	922,549
Bassinets	76,570	78,919
Patients Admitted	15,060,403	15,228,270
Births	1,856,650	1,907,772
Average Daily Census	570,331	665,105
Patient Days	208,741,146	242,763,325
Hospitals not registered	500	496
(capacity)	16,444	16,172
Hospitals applying for registration	116	101

▶ A total of 68,902 full time nurses were listed for 1945, which is 12,136 more than the 1944 figure of 56,766. The 1945 figure of 11,826 part time nurses represents an increase of 3,871 over the 7,955 shown for 1944.

▶ Full time technical personnel in all hospitals shows an increase over 1944 figures in two-thirds of the personnel classifications.

Workers who were more numerous in 1945 are laboratory technicians, dietitians, physical therapists, medical stenographers, occupational therapists and nurse anesthetists. Decreases in personnel have been reported for x-ray technicians, pharmacists and medical record librarians.

Medical Center for Care Of Children Announced

A medical center exclusively for children was announced by Children's Hospital, Boston, on April 13. The center, which will use Children's Hospital as a nucleus, is said to be the first such project to be developed.

The Boston center will have affiliated hospitals throughout the county to provide aid for any child in need of service, according to present plans.

Council Proceeds To Study Principles Of Reimbursement

The effort to establish a generally acceptable basis for the reimbursement of hospitals by Blue Cross plans made further progress in April with a meeting of the Council on Administrative Practice at which a set of principles was drafted after two days of discussion.

A special committee under this council had set out last September 5 to outline a detailed formula for figuring reimbursable costs. At a meeting in Washington January 11-12, the council and special committee drew up such a formula and submitted it to the Committee on Coordination of Activities, which returned the project for further study.

Meeting again in Chicago, April 12-13, the council and committee discussed principles rather than an operating formula. The resulting statement of principles has been submitted to all who took part in the discussion for individual study. When written recommendations have come in, a revised statement will be prepared for consideration by the council May 4-5, and the recommendations coming from this meeting will go to the coordinating committee June 7-8.

Attending the April meeeting were Council Chairman Guy J. Clark, Members Nellie Gorgas, Charles G. Roswell, Dr. Anthony J. J. Rourke, James W. Stephan, and William S. McNary, Blue Cross liaison members; John R. Mannix, E. W. Jones and Kenneth Williamson as members of the special committee; C. Rufus Rorem and George Bugbee

West Coast Medical Center Planned by Seattle Hospital

First step in the development of a proposed $3,000,000 medical center, to be built in connection with Mt. Zion Hospital, Seattle, was taken when the hospital purchased additional land on March 15.

The new property will be used as the site of an eight-story addition to the hospital. The projected building will increase bed capacity of Mt. Zion from 163 to 350 according to Dr. J. A. Katzive, director.

CONTRACT PROGRAM FOR VETERAN CARE ADVANCES SLOWLY ON SEVERAL FRONTS

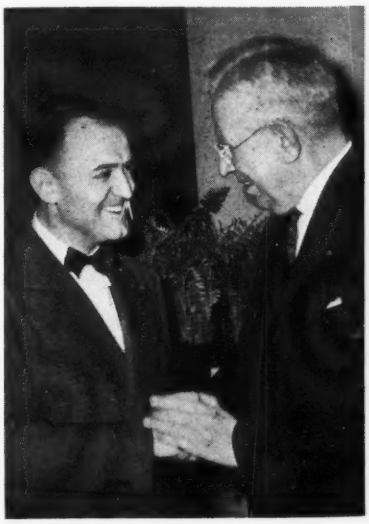
A contract arrangement whereby the Veterans Administration can purchase care in non-veteran hospitals takes shape slowly as a number of procedural knots are untied in a number of places. As of April 19 no veteran had yet been hospitalized under the proposed contract, but in both Michigan and North Carolina the first such admission was thought to be only days away.

It has turned out to be a considerable distance between the opening of negotiations and operation under contract. First the Veterans Administration must find an intermediary agency in each state that represents all organizations concerned with the program and handles all fiscal matters. Before this agency can sign the necessary master contract, it must have in hand a schedule of medical and surgical fees approved by the medical profession. The intermediary then must sign subcontracts with individual hospitals – governmental, nonprofit and proprietary. Finally the professional qualifications of each hospital must be approved by the Veterans Administration before a patient may be admitted under terms of master and subcontracts.

A sample of the complications: Michigan Hospital Service (Blue Cross) and Michigan Medical Service were first to sign a master contract. On second thought, the medical profession wanted amendments to clarify phrases dealing with the distinction between hospital and medical services. While this delayed the start of hospitalization, the medical care program went into effect April 1. At last report more than 75 per cent of Michigan's physicians had registered. Veterans with service-connected disabilities, not requiring hospitalization, were receiving medical care from their own physicians, with such authorizations running beyond 400 a day, according to Harold Lichty, director of Michigan Hospital Service.

As negotiations spread, Blue Cross organizations remained the dominant though not exclusive intermediary. Some exceptions: The Oregon Association of Hospitals, California Association of Hospitals (concerning hospital rates). Pending amendment of the enabling law in New Jersey, it is expected that a medical organization will handle all contracts.

Dr. Smith Leaves Post



Dr. Edwin L. Crosby (left), new director of Johns Hopkins Hospital, Baltimore, has a farewell word with Dr. Winford H. Smith, who retired April 1 after 35 years as hospital director. Dr. Crosby assumed his new position after almost six years as Dr. Smith's assistant.

In North Carolina, the Hospital Saving Association (Blue Cross) was signing individual hospitals to subcontracts late in April, as was the Kansas Hospital Service Corporation. Veterans Administration records showed that the signing of master contracts awaited schedules of medical and surgical fees in the following states: Massachusetts, Maine, New York, Missouri, Virginia, Tennessee, Colorado, Illinois, Arizona, Minnesota, New Hampshire-Vermont.

Hospital beds, especially for long-term care, were badly needed. Dr. Paul R. Hawley reports 10,000 men and women still in military status because they cannot be discharged to the Veterans Administration until medical and hospital care is available. Among these patients, 6,500 are tuberculous.

More Facilities. The bed shortage exists, even though the Veterans Administration gained more than 5,700 beds in the month ending April 3. The Army turned over 3,500 general, 400 tuberculosis and 600 domiciliary beds. Five additions to existing veteran hospitals produced 1,279 more—at Coatesville, Pa., Fort Custer, Mich., Chillicothe, O., Northampton, Mass., and Sheridan, Wyo. Under construction were 26 projects, plans were complete on four, and sites selected for 22. Additional projects numbering 39 await congressional approval of the necessary $140,000,000.

Little Relief Seen In Butter Shortage

(From the Washington Service Bureau)

In response to numerous reports of hospitals' inability to purchase butter, the Washington Service Bureau has made inquiry in an attempt to locate information which might help in bringing relief.

By press time only one step had been made to ease the situation. This was the announcement made late in April by Chester Bowles, director of OES, reinstating wartime restrictions on ice cream production and prohibiting production of whipping cream. The measure, which became effective May 1, is designed to divert butterfat into production of butter. Other aspects of the situation are:

1. The Department of Agriculture reports butter production at two-thirds the level of the corresponding period last year.

2. With the end of the war and food rationing that department does not believe it feasible to undertake to set aside any portion of the butter production for hospitals.

3. An alternative is that the Office of Price Administration might be asked to allow hospitals to pay one-half cent per pound above the established ceiling price. It is stated that the jobber's profit is about two cents per pound.

Whether this would induce a substantial diversion of butter from normal channels of trade to hospitals is unpredictable and no decision has been reached.

Food Management Institute Announced for Dietitians

A food institute sponsored by the Massachusetts Dietetic Association and Simmons College, Boston, will be held June 6 to 8 at the college.

To be devoted to problems of organization and management, the institute will be open to all interested dietitians.

CONSTRUCTION BEGINS ON FIRST UNITS OF $100,000,000 TEXAS MEDICAL CENTER

First units of the $100,000,000 Texas medical center are now under construction. Located in Houston, the project will bring together the combined efforts of four universities, 12 or more independent hospitals and several research institutions.

Schools participating in the program are: Baylor University, now building a $2,000,000 school of medicine to be completed in December; the University of Texas, which has announced a $6,250,000 building program at the center; the University of Houston, which will administer the central school of nursing, and Rice Institute, which will cooperate in research with other center units.

Plans for operation of the center call for the participation of each hospital in education and research. Each hospital, while maintaining its separate identity and management, is committed to a unified teaching and research program as a member of the center.

Hospitals included in the center, according to present plans, are: Hermann Hospital, which will enlarge its present building and erect a professional building for doctors and dentists practicing in the center, an affiliated urological hospital, a children's hospital, a psychosomatic pavilion and a maternity pavilion; the M. D. Anderson Hospital for Cancer Research, to be used for clinical and fundamental research and treatment; the Methodist Hospital, which plans a new building; St. Luke's Episcopal Hospital, to be constructed; and a tuberculosis hospital.

Still in the tentative stage are a Marine Hospital, a convalescent hospital and a hospital for chronic diseases and the aged. The U. S. Naval Hospital, located two blocks from the center, will cooperate in the project as will the Veterans Hospital at Houston.

Total number of beds to be supplied through the overall program are well over 2,500. Hospitals located elsewhere in Houston which have made offers of close cooperation with the center will add an additional 1,700 beds to the total.

University of Texas units which will participate in the program are: The Anderson cancer research hospital, the school of dentistry, the college of dental nursing, the institute of orthodontics, the postgraduate and graduate school of dentistry and stomatology.

Other University of Texas activities include preceptorial training for undergraduate medical sudents who will have use of all hospital facilities of the center; a graduate and postgraduate medical school; public health school with training courses for all public health workers and the institute of geographic medicine.

Additional plans for the center call for establishment of an institute of biological and pathological research and the operation of a central medical and diagnostic clinic covering the admission, examination, diagnosis and distribution of all indigent patients admitted to the center.

The Houston Academy of Medicine has made plans for a medical library and a training school for graduate librarians. Through cooperation of the Baruch Foundation for Physical Medicine, it is expected that facilities will be provided for rehabilitation of postwar and industrial injuries.

Numerous other plans for future additions to the center are still being discussed and will be announced later, according to Dr. E. W. Bertner, president of the center.

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TRI-STATE ASSEMBLY HOLDS SIXTEENTH ANNUAL MEETING IN CHICAGO MAY 1-3

Administrators, physicians, nurses, dietitians and representatives of 25 other hospital personnel classifications from Illinois, Indiana, Michigan and Wisconsin were scheduled to attend the sixteenth annual Tri-State Hospital Assembly at the Palmer House, Chicago, May 1-3.

The 29 sections of the assembly had planned a total of 50 meetings for the three afternoons. Among them were a trustees' institute scheduled for every afternoon under the chairmanship of Graham L. Davis, hospital director of the Kellogg Foundation, Battle Creek, Mich.

Other meetings on the program included three morning general assemblies, a forum on Wednesday evening, a banquet on Thursday evening and an open information quiz session on Friday afternoon.

Dr. Peter D. Ward, administrator of Charles T. Miller Hospital, St. Paul, and president of the American Hospital Association, was scheduled to discuss "Problems Confronting Hospitals" at the Wednesday forum. "The Hospital as an Educational Institution" was to be the subject of the banquet speaker, Dr. S. A. Hamrin, professor of education, Northwestern University.

Program speakers included: Dr. Arthur C. Bachmeyer, Nellie G. Brown, Dr. Roland Cross, John Mannix, Leo M. Lyons, Edna Nicholson, Dr. Norvin C. Kiefer, Dr. John B. Pastore, James A. Hamilton, Dr. Charles E. Prall, Joseph W. Towle, Homer B. Wickenden and Dr. Robin C. Buerki.

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Architects Help in Survey of Construction Conditions

The 17 architect members of the American Hospital Association who cooperated in the survey on construction conditions and reported on page 40 of this issue are:

Francis Bulfinch, Boston; Charles Butler, New York City; Thomas H. Creighton, New York City; Carl deMoll, Philadelphia; James R. Edmunds Jr., Baltimore; Carl A. Erikson, Chicago; H. Eldridge Hannaford, Cincinnati; W.P. Johnson, Erie, Pa.; Arthur S. Keene, Kansas City, Mo.

Joseph D. Leland, Boston; Luther H. Lewis, New York City; Robert J. Reiley, New York City; Richard Resler, Jersey City, N.J.; George Spearl, St. Louis; Edward Stotz, Pittsburgh; Perry W. Swern, Chicago, and Harold P. Van Arsdall, Cincinnati.

Balance of 1946 Committee Members

Part of the list of approved committee members for 1946 was published in HOSPITALS, April issue, pages 132 and 134. Included therein were committee members of the Council on Administrative Practice and some of the Council on Professional Practice appointees. The balance of the Council on Professional Practice committees and those of other councils follow:

Joint Committee of AHA and American Public Welfare Association

Fred G. Carter, M.D., chairman, St. Luke's Hospital, Cleveland; Rt. Rev. Monsignor John J. Bingham, Division Health and Hospitals, Catholic Charities of New York; Charles F. Wilinsky, M.D., Beth Israel Hospital, Boston; Stuart K. Hummell, Silver Cross Hospital, Joliet, Ill.; Howard E. Bishop, Robert Packer Hospital,

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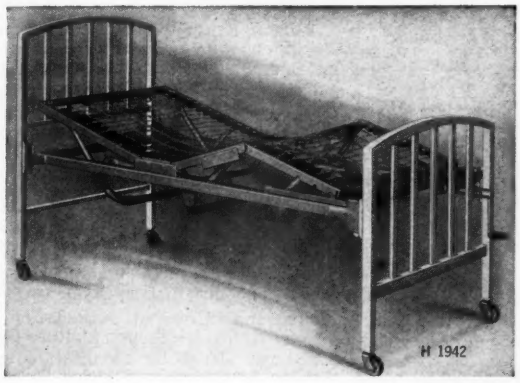

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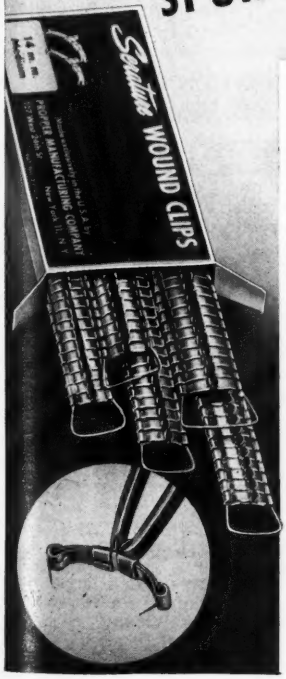

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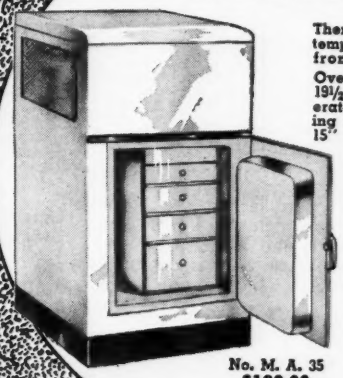

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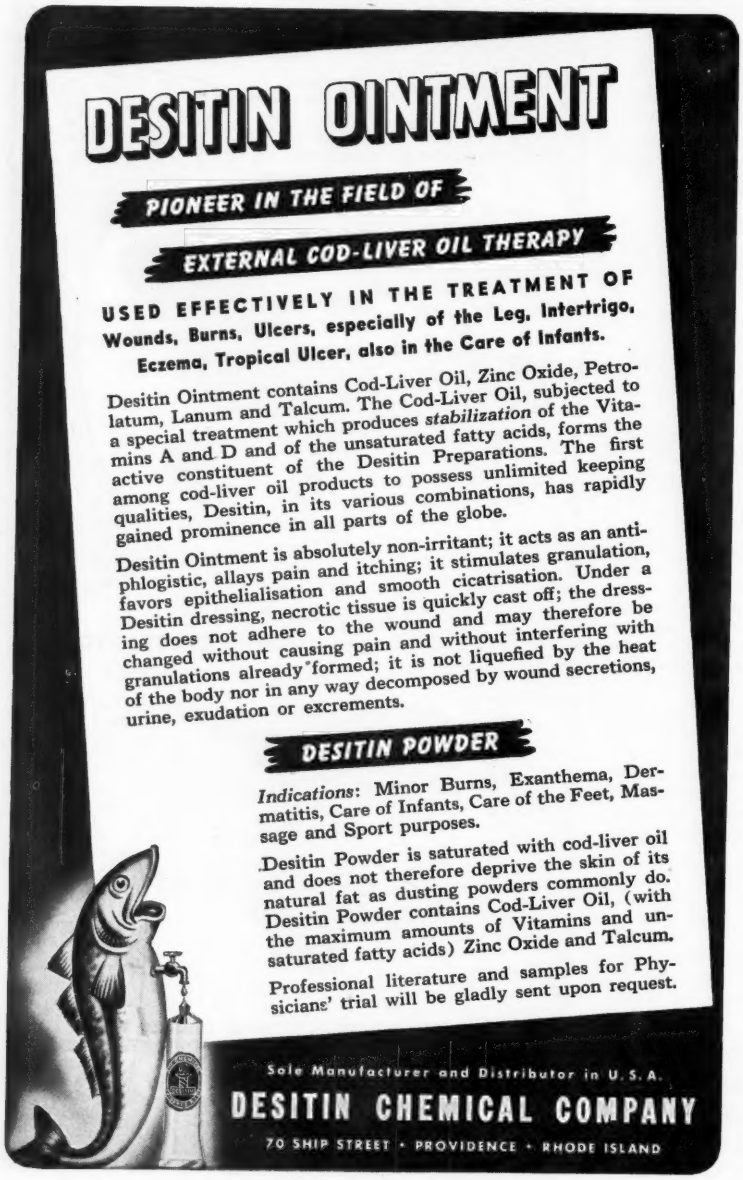
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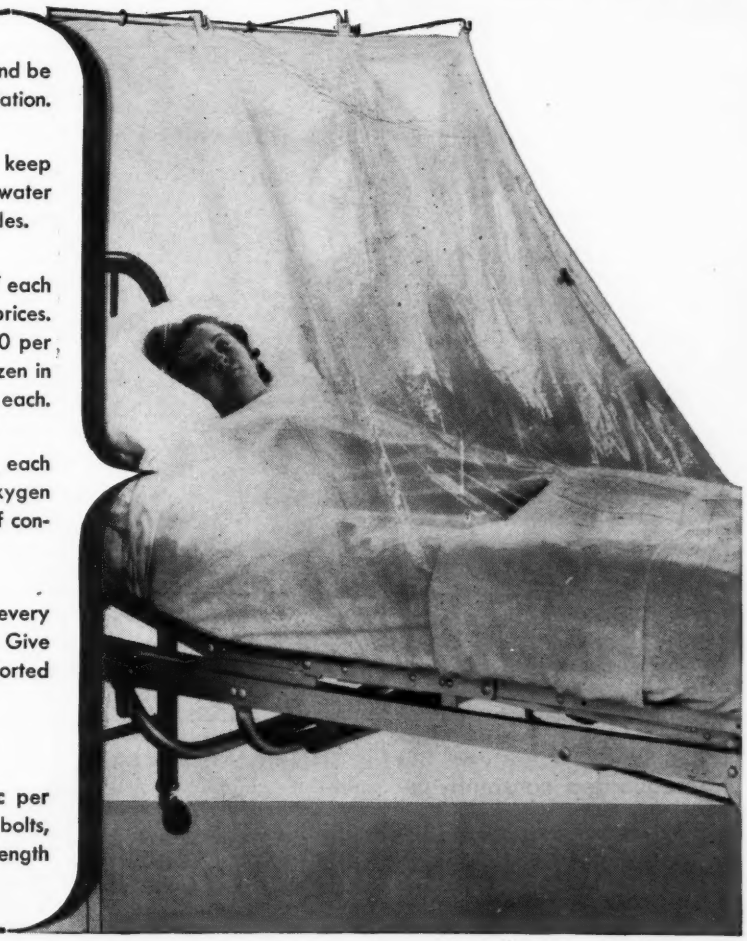

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McGILL SUMMARY ON COMMODITIES:

Production Gains Momentum

H. N. McGILL
EDITOR, McGILL COMMODITY SERVICE
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AFTER MANY false starts and setbacks caused by strikes, the race of production to the goal of mass output has finally begun. There is no fixed time table on which industries will be the first to cross the line, but we do know that during the closing half of 1946 the Federal Reserve Index, portraying the physical volume of production, will be subject to a steady and relatively broad advance.

No inroads have been made to date in the huge backlog of unfilled orders, and this leads to the question: How long will the postwar boom last? The mammoth production records chalked up during the war period emphasize our overwhelming ability to produce, and this, of course, will tend to limit the longevity of abnormally heavy industrial activity. In addition to home requirements, however, there are unprecedented opportunities in foreign trade.

Our position is that the boom will last at least three to four years. This viewpoint is substantiated by the fact that it will require four years for the automobile industry to catch up with demand. An outstanding era of new construction is scheduled for the next seven to nine years. The backlog of replacement demand for farm, electrical and office equipment assures a maximum rate of production for a period of at least three years.

While there will continue to be minor interruptions, due to labor disturbances, still there is no indication of any new setback and this will be particularly true after the uncertainty of the coal issue is settled, which will be in the immediate future. Watch industrial activity gain momentum from now on.

COMMODITY PRICE TRENDS

Commodity prices are joining the parade of increased activity. It has taken a long time to hammer home economic facts, particularly that wage rates and producing costs cannot possibly be given a free rein while at the same time commodity prices are being held on a stable basis. Some real fireworks have been witnessed in recent weeks with the composite index registering the sharpest advance since the initial influence of warfare in 1941. The latest McGill Index stands at 115.4 as compared with 111.5 at the start of the year, and currently, the level is 80 per cent above August, 1939.

Drugs and Chemicals—The index of drugs and fine chemicals is now holding on a stable plane. Considerable price adjustment has occurred since V-J Day, and there is no longer any room for broad or important price weakness. There is no question that demand will continue aggressive, and we are particularly impressed by the upward underlying trend of producing costs and the fact that the hold-the-line program is no longer a potent factor.

Paper Products—Regarding the long range status of paper, it is interesting to note that various mills are forging ahead with ambitious plans for expansion. Installation of much-needed new machinery and the accomplishing of long awaited improvements on existing equipment will play a vital part in the plan to elevate annual productive capacity of paper by some 1,000,000 tons. The industry has the ability to produce this amount as evidenced by the existing high production ratio, which for the week ending March 2 was up to 101.8 per cent of capacity.

However, the ability to maintain new production peaks is, after all, entirely contingent upon the available pulp supply, which, as has been explained, will be subject to a drop based on reduced imports in the event that the wrangle over price ceilings continues without any corrective action. The shortage of paper will continue throughout the balance of the year, and clients should keep suppliers fully informed, striving to build up some protective inventory reserve.

Cotton Goods—Even with the existing price uncertainties and OPA bungling, cotton consumption, while not experiencing any gain, has certainly not shown any drastic decrease. This in itself is a criterion of the forthcoming magnitude of replacement demand. There is hardly any question that cotton consumption for an indefinite period will hold substantially above the prewar levels. However, the principal difficulty at present is the prospect that the cost structure will again be thrown out of balance because the higher that spot prices go, the thinner are profit margins.

We have been through one siege of disrupted production due to price differentials, but there is no assurance of another adverse period later in the year. No matter from what angle the situation is approached, we know that there will be a tight supply status of finished goods for some months longer, although we are impressed by the obvious fact that inroads are being made in the backlog of unfilled orders.

Bituminous Coal—A prolonged strike cannot be tolerated, particularly in view of the setback caused by the controversy in steel. If coal production is interrupted for any length of time then steel output

MONTHLY INDICES FOR *HOSPITALS*

	Apr. 1938	Apr. 1939	Apr. 1940	Apr. 1941	Apr. 1942	Apr. 1943	Apr. 1944	Apr. 1945	Mar. 1946	Apr. 1946
ALL COMMODITIES[1]	70.3	67.3	71.0	79.0	97.2	104.8	104.5	109.1	114.1	115.4*
Industrial[1]	73.1	70.5	76.9	83.6	94.2	96.9	100.3	102.3	109.3	111.2*
Agriculture[1]	58.1	55.1	65.3	67.3	88.9	100.9	101.3	105.5	112.1	113.1*
Livestock[1]	72.8	70.7	60.6	80.1	119.1	132.4	120.5	132.6	133.0	133.6*
Food[2]	72.3	68.6	71.6	77.9	98.7	108.4	104.9	105.8	109.0e	109.4*
Factory Employment[2]	—	96.7	102.6	125.8	147.0	175.4	171.0	156.9	121.0e	124.2e
Payrolls[2]	—	93.9	150.8	150.2	222.4	324.9	339.8	321.5	215.0e	219.0e
Cost of Living[2]	100.9	99.1	99.8	102.2	115.1	124.1	124.6	127.1	129.9e	130.0e

[1]McGill Index—1926=100
[2]Bureau of Labor Index
Food—1926=100
Employment, Payrolls, Cost of Living } 1939=100

*Latest Index (weekly)
eEstimated

would again be cut drastically. This would knock the plans for economic recovery into a cocked hat. The truth of the matter is that the underlying trend of iron and steel production is again headed downward. We are progressing on the premise that there may be a tie-up in production which will last two or three weeks, but no prolonged strike. It is a foregone conclusion that mine workers will be granted a wage increase which will prove to be the basis for a mark-up in bituminous on a minimum of 25c a ton, and it would not be surprising to witness an even greater increase.

Fuel Oil—The markup in fuel oil prices of 21c per barrel is equivalent to about 90 or 95c a ton on bituminous. Currently, stocks of residual fuel oil are down sharply as compared with a year earlier, and stocks of distillate oils are below the same date in 1945. There is no danger of any shortage and production and distribution facilities will tend to increase.

Gasoline—Although prices of crude oil are facing a markup and higher prices have already been established for fuel oil, still the gasoline situation is in a class by itself. Recently, prices were cut fractionally in the Gulf Coast area, and this is bound to have a psychological effect upon the attitude toward prices along the eastern seaboard. The statistical position has eased conspicuously as compared with a year ago.

Groceries—There is a lot of talk about a shortage of foodstuffs in the United States, but that is largely propaganda. We are shipping larger quantities abroad, but there will still be a fairly sizable carry-over at the end of this producing season.

Butter—The situation continues to grow worse, and this is illustrated by noting that output during the first two months of this year was only 136,145,000 pounds compared with 184,414,000 a year earlier, and 237,845,000 four years ago. It is necessary to go back to 1921 to find production of butter lower than the current figure. Cold storage holdings are only a mere fraction of the normal complement.

Cheese—Output last year was 1,114,764,000 pounds, which surpassed all previous peaks by an extensive margin. The former high was in 1942, of 1,108,849,000 pounds, and only seven years ago, in 1939, production was down to 680,567,000 pounds. Hence, in the course of a relatively few years over-all production has increased 64 per cent. Production so far this year is not quite up to the peaks of a year ago.

Eggs—Latest data show that farm flocks laid 4,954,000,000 eggs in February—3 per cent more than in the same month last year, and 45 per cent more than in the ten-year average for 1935-44. This has taken place despite a 1 per cent decrease in the number of layers, because production was up 4 per cent per layer.

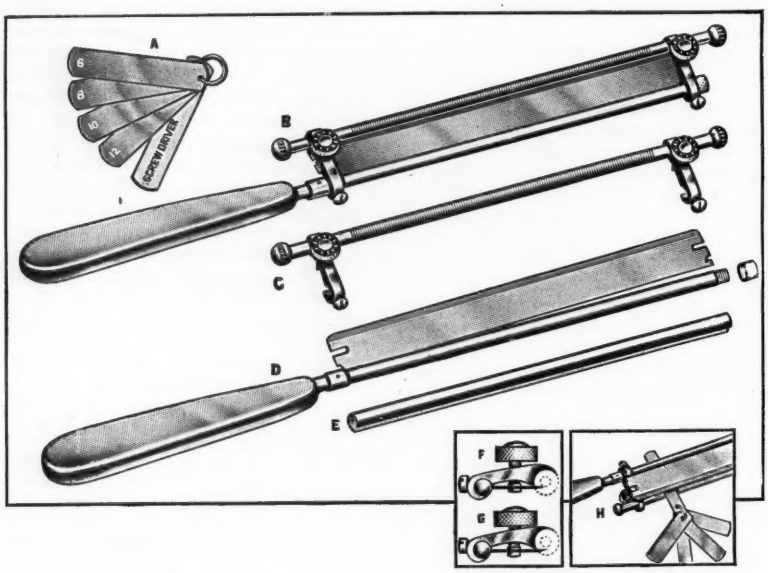
Surplus Property

(From the Washington Service Bureau)

Administrative reorganization with a restatement of aims for disposal of surplus property has yet to make its effect felt. Non-governmental nonprofit hospitals must still exercise alertness and initiative to get results in their purchasing plans.

From July 1945 to March 23, 1946, sales of medical and surgical supplies total $6,625,000. Of that amount an estimated $6,000,000 presumably went to federal, state and local governments, for a recent statement by the now defunct War Assets Corporation reported that those groups received about 90 per cent of declared surplus in this classification.

The closing inventory of listed supplies for March 23 was $43,526,000. The inventory included: diagnostic apparatus, $591,000; surgical instruments, $6,000,000; operating room and other hospital equipment, $5,977,000; prescription drugs and remedies, $2,509,000 and, sur-



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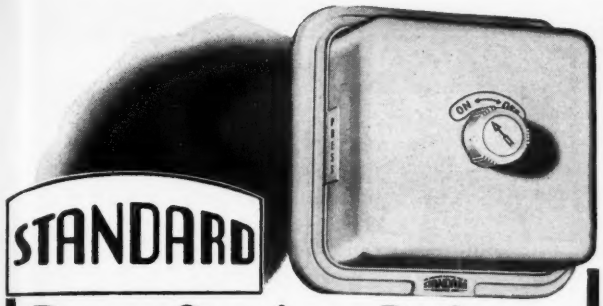

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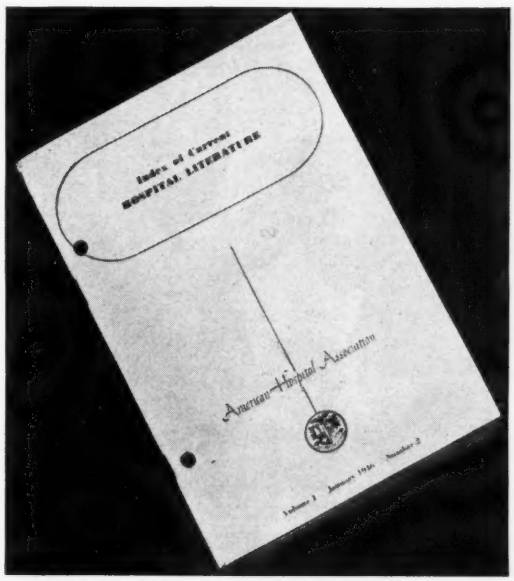

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gical, medical and dental supplies, $8,040,000.

The War Assets Administration, with Lt. Gen. Edmund B. Gregory as administrator, is now the chief disposal agency. It replaces WAC and its predecessors. To fulfill its policy of decentralization it will:

1. Give its 33 regional directors authority to initiate sales of property amounting to $1,000,000 without detailed Washington approval.

2. Give regional directors more freedom in their choice of methods of sale.

3. Sell as much surplus as possible at fixed prices.

4. Attempt to simplify procedures for allocation of surplus items to conform as closely as feasible to normal trade practices.

5. Provide for effecting leases, extending loans, credits and deferred payments in surplus sales transactions.

To further facilitate disposal of surplus, coordinators are now working in regional WAA offices to put a nationwide site-sales plan into operation. It is expected that coordination work will be completed early in May, and that dates for the first sales will be announced soon after that.

Under the site sale program buyers are permitted to purchase surplus property on the spot where they inspect samples, make their selections, arrange transportation and pay for the goods.

The number of locations that may finally be approved for site sales might reach 2,000. The present arrangement is for 532. The nation's first site sale was conducted at Port Hueneme, Calif., where 81 per cent of the materials offered were disposed of, with recovery of 59.9 per cent of the original cost to the government.

Non-government nonprofit hospitals' opportunities for obtaining material for the present were not otherwise strengthened during the past month. Not until federal agencies with top priorities and state and local government needs have been satisfied can non-government hospitals expect sizable deliveries.

Small businesses, which actually rated below hospitals in preference, in many cases now command a position on a par with federal government agencies. Through the Reconstruction Finance Corporation—a government agency as purchasing agent with top priority—they can purchase medical and surgical supplies when prerequisites of extreme necessity are met. Small business is defined as one that does not dominate its particular field, that employs less than 500 persons, and is organized for profit. Because hospitals are nonprofit and primarily professional they do not qualify as small business, a government spokesman has stated.

It was also announced by the WAA that priority claimants, including federal agencies, state and local governments, were expected to absorb all inventories in three separate nationwide sales of hospital equipment and supplies being held between April 11 and May 3. The supplies listed originally cost the government $248,298.

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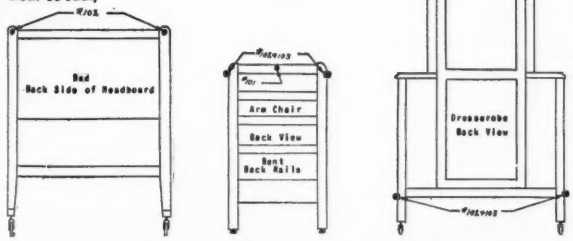

Showing suggested locations of HILL-ROM bumpers on typical items of hospital furniture.

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Personal News

LIEUT. IRA L. ERNST, on duty with the Navy since 1942, was released to inactive duty March 30 and has been appointed controller of Monmouth Memorial Hospital, Long Branch, N. J. Prior to entering the Navy he was employed at the University of Michigan Hospital, Ann Arbor.

CMDR. I. S. GEETTER, M.D., former medical director of New Britain (Conn.) General Hospital, was scheduled to become director of Mt. Sinai Hospital, Hartford, May 1, following termination of service in the U. S. Navy. He is a personal member of the American Hospital Association.

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Pictured is surgeon's gown No. 331.
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LAURENCE THORNTON, formerly assistant administrator of Rex Hospital, Raleigh, N.C., has been appointed administrator of the institution, succeeding CLAUDE GADDY who has accepted the position of executive secretary of the Baptist State Council on Christian Education.

MAJ. LAWRENCE C. AUSTIN, after 40 months of active duty in the Medical Administrative Corps, has been separated from service and is on terminal leave until May 18. After basic training at Camp Grant, Ill., he was sent to the station hospital at Fort Lewis, Wash., where he directed personnel which included 700 civilians. In addition he was hospital inspector and assistant executive officer and medical supply officer of one of the 500 bed sections.

Later he was picked with two other officers and two enlisted men for an advance group to proceed to Wales for the purpose of setting up a hospital for oncoming tank groups. When the armored units moved to France shortly thereafter his hospital was sent to London to take over the headquarters hospital.

Major Austin, who is also a veteran of World War I, is well known in civilian hospital circles, having served as assistant superintendent of Michael Reese Hospital, Chicago; administrator of Mt. Sinai Hospital, Milwaukee, and administrator of Menorah Hospital, Kansas City, Mo. He is a personal member of the American Hospital Association and a charter fellow of the American College of Hospital Administrators.

CHARLES H. DABBS, former superintendent at Northeastern Hospital, Philadelphia, is now administrator of American University Hospital, Beirut, Syria. He is a personal member of the American Hospital Association and a fellow of the American College of Hospital Administrators.

R. G. BALL, recently discharged from the Army Medical Corps, has been elected business manager of Maria Parham Hospital Association, Henderson, N.C.

MRS. GERTRUDE R. FOLENDORF, R.N., of San Francisco, administrator of the 16 Shriners' Hospitals for Crippled Children, has been appointed to the Board of Regents of the American College of Hospital Administrators. She fills the vacancy created by the recent death of Benjamin W. Black, M.D., former medical director of Alameda County Institutions and administrator of Highland-Alameda County Hos-

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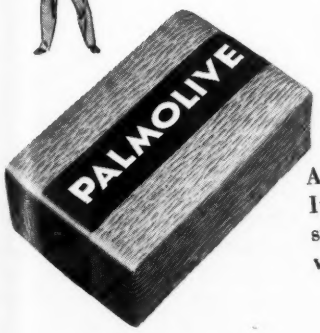

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pital, Oakland, Calif. In addition to being a personal member of the American Hospital Association and a fellow of the American College of Hospital Administrators, Mrs. Folendorf is a past president of the California State Nurses Association and of the California League of Nursing Education.

MALCOLM L. MONROE has been appointed to the board of administrators of Charity Hospital, New Orleans, succeeding WALKER SAUSSY, resigned.

S. K. PROCTOR has assumed the duties of administrative assistant at City Hospital, Winston-Salem, N.C. He recently was discharged from the Army Air Corps after serving 30 months overseas in the India-Burma Theater.

DONALD N. ABBOTT, who left the position of comptroller of Cortland (N.Y.) General Hospital to serve with the Army Medical Corps, has returned to that institution as administrator.

ALFRED GOLDEN, M.D., has assumed the duties of associate director of the pathological laboratories at Baptist Hospital, Memphis.

P. G. HOWE has been elected president of St. Luke's Hospital Association, Jacksonville, Fla.

AERO-KLENZ furnishes a simple means of eliminating offensive odors. An aqueous solution of potassium mercuric iodide and sodium hydroxide,* it reacts instantly with organic odors—destroying them either at their source or after they escape into the air.

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AERO-KLENZ

WENDELL H. CARLSON has succeeded CLARA B. POND, R.N., as superintendent of Ingalls Memorial Hospital, Harvey, Ill. Both are personal members of the American Hospital Association.

GEORGE PECK, who resigned the superintendency of Illinois Eye and Ear Infirmary, Chicago, to become administrator of Jewish Hospital, Philadelphia, has been succeeded by LESTER GERBER.

KENNETH H. GORDON has assumed the duties of assistant director of Woman's Hospital, New York City, succeeding EMILY W. BAUER, R.N., retired. Mr. Gordon recently completed his terminal leave after serving 30 months with the United States Naval Reserve. Prior to military service, he was superintendent of Green County Memorial Hospital, Waynesburg, Pa.

ROBERT L. GILL, superintendent of Altoona (Pa.) Hospital, has been elected president of the Central Pennsylvania Regional Hospital Association. He is a personal member of the American Hospital Association.

LIALA I. JOHANSON, R.N., personal member of the American Hospital Association, is the new superintendent of nurses at Lake Forest (Ill.) Hospital.

FRED E. MILLS, M.D. has been appointed pathologist at Protestant Deaconess Hospital, Evansville, Ind.

MACIE N. KNAPP, R.N., has been named superintendent of Cass County Hospital, Logansport, Ind., succeeding LUCILLE JAKES, R.N., resigned. Miss Knapp is a personal member of the American Hospital Association and a fellow of the American College of Hospital Administrators.

ADELE M. POLK, R.N., personal member of the American Hospital Association, has resumed the superintendency of St. Margaret Memorial Hospital, Pittsburgh, following a recent ailment. LOUISE LUDEWIG, who filled the post during Miss Polk's absence, remains as assistant superintendent.

FRANK M. B. SLATER, M.D., has assumed the position of resident surgeon at Vicksburg (Miss.) Hospital. Dr. Slater has been associated with the Hinds County health unit in Jackson.

R. C. WARREN has been appointed superintendent of Georgia Baptist Hospital, Atlanta. He was assistant administrator of Baptist State Hospital, Little Rock, Ark., the past 11 years.

LIEUT. COL. ERNEST V. EDWARDS has been made manager of Birmingham General (Army) Hospital, Van Nuys, Calif.

HERMAN J. GRIMMER JR., principal hospital administrator for the Institute of Inter-American Affairs in Ecuador, after a period of consultation in Washington, D.C., and a sick leave for hospitalization in New York City, has returned to his official station in Guayaquil, Ecuador.

Mr. Grimmer is consultant on hospitals for the Junta de Beneficencia of the city of Guayaquil and administrator of the

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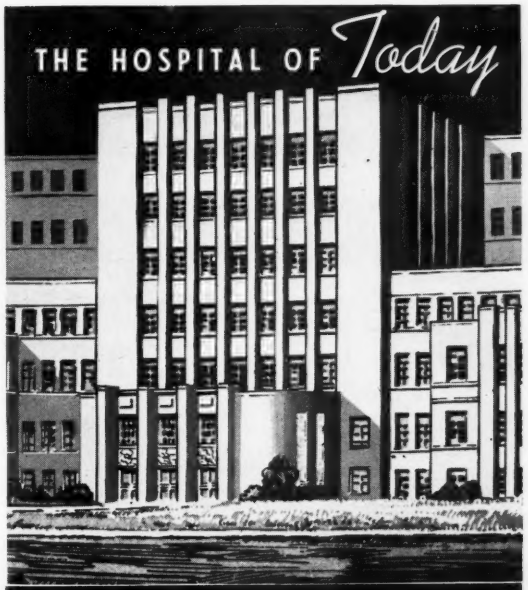

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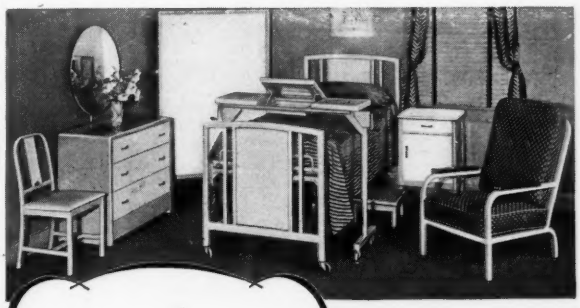

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700-bed general hospital there. He also is in charge of equipping and organizing a 288-bed tuberculosis hospital in Guayaquil for the Anti-Tuberculosis League of Ecuador, and a 170-bed maternity hospital in that city. Mr. Grimmer is a personal member of the American Hospital Association.

JAMES E. FISH, M.D., has been appointed director of Ellis Hospital, Schenectady, N.Y., to succeed MARY G. MCPHERSON, R.N., who is retiring after more than 21 years' service as administrator of the institution.

BURTON H. MORRELL has resigned the superintendency of Princeton (N.J.) Hospital.

EVELYN JOHNSON, formerly executive secretary of the Chicago Hospital Council, is the new superintendent of Brokaw Hospital, Normal, Ill. She is a personal member of the American Hospital Association.

EDITH PRITCHARD has been appointed director of nursing at Beverly (Mass.) Hospital.

RICHARD T. VIGUERS has returned to his former position, associate in the division of rural hospitals of the Commonwealth Fund, after four years of service in the Medical Administrative Corps. A personal member of the American Hospital Association, Mr. Viguers for the past year has been executive officer of Brooke Convalescent Hospital, Fort Sam Houston, Tex.

ARTHUR J. ANDERSON has been appointed business manager of Eugene (Ore.) Hospital and Clinic, succeeding MARVIN T. WARLICK, resigned.

MRS. FRANCIS LAMPERT, R.N., has resigned the superintendency of nurses at Black Hills General Hospital, Rapid City, S.D. She is succeeded by ALICE HAYS, R.N.

MRS. ALMA MEYER ZEISSEL has been appointed acting superintendent of Wichita General Hospital, Wichita Falls, Tex., replacing MRS. MARGARET HALES ROSE, R.N., resigned. Mrs. Rose is a personal member of the American Hospital Association.

LLOYD GILBERT has assumed the duties of administrative assistant and purchasing agent at North Carolina Baptist Hospital, Winston-Salem.

WILLARD L. QUENNELL, M.D., has resigned the position of director of Union Memorial Hospital, Baltimore, to take a post with the veterans administration. A personal member of the American Hospital Association, he will be located temporarily at Rutland Center, Mass.

ANTHONY W. ECKERT who has been on leave of absence from his post as superintendent of Fitkin Memorial Hospital, Neptune, N.J., while serving in the medical corps, has resumed his hospital position. Mr. Eckert was stationed at Fitzsimons General Hospital, Denver, Colo., in the capacity of director of the dietetic division, custodian of hospital funds and director of the dietetic school. He is a personal member of the American Hospital Association and a member of the American College of Hospital Administrators.

HENRY FREEMAN ALLEN, M.D., DAVID HENRY SCOTT, M.D., and WILLIAM LLOYD SMITH, M.D., have been appointed to residencies on the opthalmological service at the Massachusetts Eye and Ear Infirmary, Boston.

Deaths

NILS A. JOHANSON, M.D., 74-year-old medical superintendent and principal founder of Swedish Hospital, Seattle, died March 7 at the hospital.

Born in Lund, Sweden, Dr. Johanson came to this country to attend the World's Fair in 1893. He graduated from the Universiy of Colorado Medical School in 1903, going to Seattle four years later. In 1908, with nine others, he organized the Swedish Hospital as a nonprofit organization. After completion of the hospital, he took a leave of absence for post-graduate study in surgery in Vienna in 1913, and for further research in Stockholm in 1930.

A personal member of the American Hospital Association, Dr. Johanson served as president of Swedish Hospital's board of directors from 1938 to 1945, when he became chief of staff.

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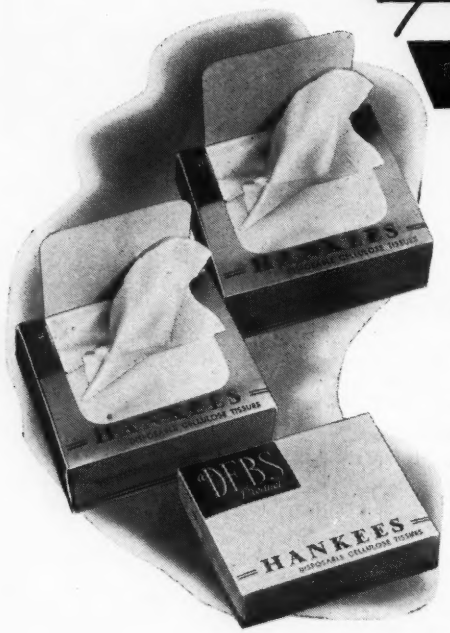

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